CHAPTER 300

MEDICAL POLICY FOR AHCCCS COVERED SERVICES

CHAPTER 300

MEDICAL POLICY FOR AHCCCS COVERED SERVICES

CHAPTER 300

MEDICAL POLICY FOR AHCCCS COVERED SERVICES

300 CHAPTER OVERVIEW

This chapter provides information about the acute care services that are covered by the AHCCCS. The AHCCCS acute care program offers comprehensive preventive, acute and behavioral health care services with limited coverage of rehabilitative services, home health care and long term care, as specified in Arizona Administrative Code Title 9, Chapter 22, Article 2. The latter services are covered more extensively through the Arizona Long Term Care System (ALTCS). All covered services must be medically necessary and provided by a primary care provider, or other qualified providers as defined in Chapter 600 of this Manual. Out-of-state services are covered as provided for under Title 42 of the Code of Federal Regulations, Part 431, Subpart B. This includes services that, as determined on the basis of medical advice, are more readily available in other states, and services needed due to a medical emergency. Services furnished to AHCCCS members outside the United States are not covered. AHCCCS will not register providers who are located outside the United States or who provide services solely outside the United States.

This chapter does not discuss maternal and child health services or services provided through the Federal Emergency Service Program (FESP). Maternal and child health services, including the KidsCare program (Title XXI), are described in Chapter 400. FESP services are described in Chapter 1100.

Exhibit 300-1 identifies covered AHCCCS acute care program services and Exhibit 300-2 identifies covered behavioral health services for Title XIX and Title XXI members.

The remaining pages of this chapter provide a description and a discussion of the amount, duration and scope limitations based on member eligibility and/or member age for AHCCCS acute care program services. Prior authorization (PA) requirements for covered services are not provided in this chapter.

AHCCCS PA requirements for covered services provided by Contractors are focused on inpatient hospital services and AHCCCS requires Contractors to implement an appropriate PA procedure for inpatient hospital services. AHCCCS also encourages Contractors to implement PA and utilization management methods for other services as appropriate. Specific Contractor PA requirements are not identified in this Manual; for details regarding Contractor PA requirements for specific services, contact the Contractor.

If a service requiring PA is denied by a Contractor or by AHCCCS Administration, notice of action must be provided to the member in accordance with Arizona Administrative Code Title 9, Chapter 34 (9 A.A.C. 34).

AHCCCS requires Division of Fee for Service Management (DFSM) PA for many covered acute services that are provided to a fee-for-service (FFS) member, (i.e., a member not enrolled with a Contractor). Exceptions include emergency services including emergency dental and behavioral health services.

AHCCCS PA requirements for services provided to FFS members are specified in Chapter 800. Refer to the PA section of Policy 810 for information regarding requirements for notification of FFS providers and FFS members if PA is denied. Refer to the concurrent review section of Policy 810 for information related to approval or denial of the continuation of inpatient hospital services for FFS members.

Refer to Chapter 1600 for information on ALTCS program covered services that require PA.

Refer to the AHCCCS FFS Provider Manual and the Encounter Reporting User Manual for complete information regarding claim and encounter reporting procedures for covered services. These manuals are both available on the AHCCCS Web site (www.ahcccs.state.az.us).

- **REFERENCES**

1. Title 42, Code of Federal Regulations (42 CFR) Part 440 (Services, General Provisions)

2. Arizona Revised Statutes (A.R.S.) Title 36, Chapter 29, Articles 1-5

3. Arizona Administrative Code (A.A.C.) Title 9, Chapter 22, 28 and 31

4. Chapter 100 of this Manual includes 42 CFR, State Statute and Rule citations related to services and settings addressed in the Chapter.

5. Chapter 600 of this Manual, Exhibit 610-1, includes 42 CFR, State Statute and Rule citations related to provider requirements.

6. AHCCCS Contracts

7. AHCCCS memo dated September 4, 1997, entitled "Medicaid Payments for Foreign Country Providers".

EXHIBIT 300-1

AHCCCS COVERED SERVICES
ACUTE CARE

EXHIBIT 300-1
AHCCCS COVERED SERVICES
ACUTE CARE*

SERVICES	TITLE XIX		TITLE XXI
	<21	>21	<19
Audiology	X	X	X
Behavioral Health	SEE EXHIBIT 300-2		
Breast Reconstruction After Mastectomy	X	X	X
Chiropractic Services	X		X
Cochlear Implants	X	X	X
Dental Services			
Emergency Dental Services	X	X	X
Medically Necessary Dentures	X	X	X
Preventive & Therapeutic	X		X
Dialysis	X	X	X
Emergency Services-Medical	X	X	X
Eye Examination/Optometry			
Emergency Eye Exam	X	X	X
Vision Exam/Prescriptive Lenses	X		X
Lens Post Cataract Surgery	X	X	X
Treatment for Medical Conditions of the Eye	X	X	X
Health Risk Assessment & Screening Tests (over 21)		X	
HIV/AIDS Antiretroviral Therapy	X	X	X
Home Health Services	X	X	X
Hospice	X		X
Hospital Services			
Inpatient Medical	X	X	X
Observation	X	X	X
Outpatient Medical	X	X	X
Hysterectomy (medically necessary)	X	X	X
Immunizations	X	X	X
Laboratory	X	X	X
Maternal & Child Health Services			
Maternity Services	X	X	X
Family Planning	X	X	X
Early and Periodic Screening, Diagnosis and Treatment (Medical Services)	X		X

See Chapter 300 for age and service delivery site restrictions, scope and time limitations, provider specialty requirement and eligibility limitations.
See Chapter 400 for Maternal and Child Health Service restrictions and limitations.
See Chapter 800 for FFS/PA requirements.
See Chapter 1100 for covered services for the Emergency Services Program (ESP).

EXHIBIT 300-1
AHCCCS COVERED SERVICES
ACUTE CARE*

SERVICES	TITLE XIX		TITLE XXI
	<21	>21	<19
Other Early and Periodic Screening, Diagnosis and Treatment Services Covered By Title XIX	X		X
Medical Foods	X	X	X
Medical Supplies/Equipment			
Durable Medical Equipment	X	X	X
Medical Supplies	X	X	X
Prosthetic/Orthotic Devices	X	X	X
Nursing Facilities (up to 90 days)	X	X	X
Non-Physician First Surgical Assistant	X	X	X
Physician Services	X	X	X
Podiatry	X	X	X
Prescription Drugs	X	X	X
Primary Care Provider Services	X	X	X
Private duty nursing	X	X	X
Radiology and Medical Imaging	X	X	X
Rehabilitation Therapies			
Occupational Therapy - Inpatient	X	X	X
Occupational Therapy - Outpatient	X		X
Physical Therapy	X	X	X
Speech Therapy - Inpatient	X	X	X
Speech Therapy - Outpatient	X		X
Respiratory Therapy	X	X	X
Total Outpatient Parenteral Nutrition	X	X	X
Transplantation			
Non-Experimental transplants approved for Title XIX reimbursement	X	X	X
Related immunosuppressant drugs	X	X	X
Transportation - Emergency	X	X	X
Transportation - Non-emergency	X	X	X
Triage	X	X	X

See Chapter 300 for age and service delivery site restrictions, scope and time limitations, provider specialty requirement and eligibility limitations.
See Chapter 400 for Maternal and Child Health Service restrictions and limitations.
See Chapter 800 for FFS/PA requirements.
See Chapter 1100 for covered services for the Emergency Services Program (ESP).

EXHIBIT 300-2

AHCCCS COVERED SERVICES
BEHAVIORAL HEALTH

EXHIBIT 300-2
AHCCCS COVERED SERVICES
BEHAVIORAL HEALTH

SERVICES	ACUTE CARE		ALTCS				CHIP* XXI
	XIX		EPD		DD		
	<21	≥21	<21	≥21	<21	≥21	<19
Behavioral Management	X	X	X	X	X	X	X
Case Management	X	X	X	X	X	X	X
Emergency Behavioral Health Care	X	X	X	X	X	X	X
Evaluation	X	X	X	X	X	X	X
Therapeutic Foster Care	X	X	X	X	X	X	X
Inpatient Services							
Inpatient Hospital	X	X	X	X	X	X	X
Inpatient Psychiatric Facilities	X	X	X	X	X	X	X
Laboratory and Radiology	X	X	X	X	X	X	X
Medications (Psychotropic)	X	X	X	X	X	X	X
Medication Adjustment and Monitoring	X	X	X	X	X	X	X
Methadone/LAAM	X	X	X	X	X	X	X
Partial Care	X	X	X	X	X	X	X
Professional Services – Therapy and Counseling							
Individual	X	X	X	X	X	X	X
Group and Family	X	X	X	X	X	X	X
Psychosocial Rehabilitation	X	X	X	X	X	X	X
Respite (with limitations)	X	X	X	X	X	X	X
Screening	X	X	X	X	X	X	X
Transportation							
Emergency	X	X	X	X	X	X	X
Non-Emergency	X	X	X	X	X	X	X

See Appendix G for restrictions, scope and time limitations, provider requirements and eligibility limitations for Title XIX and Title XXI behavioral health services.

310 COVERED SERVICES

- **AUDIOLOGY**

Description. Audiology is an AHCCCS covered service, within certain limitations, to evaluate hearing loss and rehabilitate persons with hearing loss through other than medical/surgical means.

Amount, Duration and Scope. AHCCCS covers medically necessary audiology services to evaluate hearing loss for all members, on both an inpatient and outpatient basis. Hearing aids can be dispensed only by a dispensing audiologist or an individual with a valid hearing aid dispensing license. Hearing aids, provided as a part of audiology services, are covered only for members receiving EPSDT services and KidsCare members up to age 21.

Beginning June 28, 2004, audiology services must be provided by an audiologist who is licensed by the Arizona Department of Health Services (ADHS) and who meets the Federal requirements specified under Title 42 of the Code of Federal Regulations (42 CFR) 440.110. Out-of-state audiologists must meet the Federal requirements.

The Federal requirements mandate that the audiologist must have a Master's or Doctoral degree in audiology and meet one of the following conditions:

1. Have a certificate of clinical competence in audiology granted by the American Speech-Language-Hearing Association (ASHA), or

2. Have successfully completed a minimum of 350 clock-hours of supervised clinical practicum (or be in the process of accumulating such supervised clinical experience under the supervision of a qualified Master's or Doctoral-level audiologist), performed not less than nine months of supervised full-time audiology services after obtaining a Master's or Doctoral degree in audiology or a related field, and successfully completed a national examination in audiology approved by the Secretary of the U.S. Department of Health and Human Services.

Refer to Chapter 1200 for additional information on services provided to ALTCS members.

BEHAVIORAL HEALTH SERVICES

Description. AHCCCS covers behavioral health services (mental health and/or substance abuse services) within certain limits for all members except those enrolled to receive family planning extension services only. The following outlines the service delivery system for behavioral health services.

Acute Care Program

1. Title XIX and Title XXI Members are eligible to receive medically necessary behavioral health services. Services are provided through the Arizona Department of Health Services and its contracts with Regional Behavioral Health Authorities (RBHAs) and Tribal Regional Behavioral Health Authorities (TRBHAs). Native American members may receive behavioral health services from an IHS/638 facility, a TRBHA, or be referred to a RBHA. Services are listed in the amount, duration and scope section of this policy and described with limitations in Appendix G, the Behavioral Health Services Guide. Managed care primary care providers, within the scope of their practice, who wish to provide psychotropic medications and medication adjustment and monitoring services may do so for members diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder, mild depressive and/or anxiety disorders.

   Contractors are responsible for providing inpatient emergency behavioral health services for up to 72 hours after admission to managed care members with psychiatric or substance abuse diagnoses who are enrolled with a Contractor and are not behavioral health recipients (not to exceed 12 days per contract year).

2. Family Planning Extension Program Members enrolled in the SOBRA Family Planning Extension Program are not eligible for behavioral health services.

Arizona Long Term Care System (ALTCS) Program

ALTCS members are eligible to receive medically necessary behavioral health services through ALTCS Contractors, Tribal Contractors, Department of Economic Security/Division of Developmental Disabilities, and AHCCCS registered fee-for-service (FFS) providers. Refer to Appendix G and Chapters 1200 and 1600 of this Manual for additional information regarding ALTCS behavioral health services.

Amount, Duration and Scope.

Covered behavioral health services for acute and ALTCS members include, but are not limited to:

1. Inpatient hospital services
2. Inpatient psychiatric facility services including subacute facilities and residential treatment centers for persons under age 21
3. Institution for mental disease with limitations (See Appendix G)
4. Behavioral health counseling and therapy, including electroconvulsive therapy
5. Psychotropic medication
6. Psychotropic medication adjustment and monitoring
7. Respite care
8. Partial care (supervised day program, therapeutic day program and medical day program)
9. Behavior management (behavioral health personal care, behavioral health home care training, behavioral health self-help/peer support)
10. Psychosocial rehabilitation (skills training and development, behavioral health promotion/education, psychoeducational services, ongoing support to maintain employment, and cognitive rehabilitation)
11. Screening, evaluation and assessment
12. Case management services
13. Laboratory, radiology, and medical imaging services for diagnosis and psychotropic medication regulation

14. Emergency and non-emergency medically necessary transportation

15. Therapeutic foster care, and/or

16. Emergency behavioral health services for managed care and FFS members who are not in the FESP (refer to Chapter 1100 for all requirements regarding FESP).

    a. Emergency behavioral health services are described under A.A.C. R9-22-210.01. An emergency behavioral health condition is a condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

        1) Placing the health, including mental health, of the member in serious jeopardy (this includes serious harm to self)

        2) Serious impairment to bodily functions

        3) Serious dysfunction of any bodily organ or part, or

        4) Serious physical harm to another person.

    Acute symptoms include severe psychiatric symptoms.

    b. An emergency behavioral health evaluation is covered as an emergency behavioral health service if:

        1) Required to evaluate or stabilize an acute episode of mental disorder or substance abuse, and

        2) Provided by a qualified provider who is:

            a) A behavioral health medical practitioner as defined in 9 A.A.C. 22, Article 1, including a licensed psychologist, a licensed clinical social worker, a licensed professional counselor, a licensed marriage and family therapist, or

            b) An ADHS/DBHS-contracted provider.

A provider is not required to obtain prior authorization for emergency services. Regarding emergency services, refer to Exhibit 310-1 for a reprint of A.A.C. R9-22-210.01 that describes general provisions for responsible entities, payment and denial of payment, notification requirements and post-stabilization requirements.

Refer to A.A.C. R9-22-217 and Chapter 1100 of this Manual for information regarding behavioral health services for members eligible for services through the Federal Emergency Services Program.

Refer to Chapter 1200 for more information regarding behavioral health services for members eligible for the ALTCS program.

Refer to Appendix G for further information on AHCCCS covered behavioral health services and settings.

- **BREAST RECONSTRUCTION AFTER MASTECTOMY**

Description. AHCCCS covers breast reconstruction surgery for eligible members following a medically necessary mastectomy regardless of AHCCCS eligibility at time of mastectomy.

Amount, Duration and Scope. Breast reconstruction surgery is a covered service if the individual is AHCCCS eligible, and as noted in this section. The member may elect to have breast reconstruction surgery immediately following the mastectomy or may choose to delay breast reconstruction, but the member must be AHCCCS eligible at the time of breast reconstruction surgery. The type of breast reconstruction performed is determined by the physician in consultation with the member.

Coverage policies for breast reconstructive surgery include:

1. Reconstruction of the affected and the contralateral unaffected breast following a medically necessary mastectomy is considered an effective non-cosmetic procedure. Breast reconstruction surgery following removal of a breast for any medical reason is a covered service.

2. Medically necessary implant removal is a covered service. Replacement of implants is a covered service when the original implant was the result of a medically necessary mastectomy. Replacement of implants is not a covered service when the purpose of the original implant was cosmetic (e.g., augmentation).

3. External prostheses, including a surgical brassiere, will be covered for members who choose not to have breast reconstruction, or who choose to delay breast reconstruction until a later time. Refer to the durable medical equipment (DME) policy in this Chapter for information regarding covered DME services.

Limitations:

1. AHCCCS does not cover services provided solely for cosmetic purposes (R9-22-205). If a member has had an implant procedure for cosmetic purposes (e.g., augmentation) not related to a mastectomy, medically necessary removal is covered but replacement is not.

2. Reconstructive breast surgery of the unaffected contralateral breast following mastectomy will be considered medically necessary only if required to achieve relative symmetry with the reconstructed affected breast. Except in extraordinary circumstances, the medical necessity of reconstructive breast surgery must be determined by the surgeon, in consultation with the Contractor's Medical Director, at the time of reconstruction or during the immediate post-operative period.

Prior authorization (PA) from the AHCCCS Division of Fee for Service Management is required for breast reconstruction surgery provided to FFS members. Refer to Chapter 800 for further discussion of PA requirements for FFS providers.

- **DENTAL SERVICES FOR MEMBERS 21 YEARS OF AGE AND OLDER**

Description. AHCCCS covers the following dental services, provided by a licensed dentist, for members who are 21 years of age and older:

1. Emergency dental services

2. Medically necessary dentures, and

3. Pre-transplant dental services.

Dental services for members younger than age 21, including preventive and therapeutic dental services, are discussed in Chapter 400 of this Manual.

Amount, Duration and Scope.

AHCCCS requires Contractors to provide at least the following:

1. Coordination of covered dental services for enrolled AHCCCS members

2. Documentation of current valid contracts with dentists who practice within the Contractor service area(s)

3. Primary care provider to initiate member referrals to dentist(s) when the member is determined to be in need of dental emergency services, or members may self-refer to a dentist when in need of emergency dental services.

4. Monitoring of the provision of dental services and reporting of encounter data to AHCCCS, and

5. Assurance that copies of Contractor, and AHCCCS, emergency dental policies and procedures have been provided to contracted dentist(s).

Emergency Dental Care - Medically necessary emergency dental care and extractions are covered for all members who meet the criteria for an emergency as defined in this Chapter for managed care members, Chapter 800 for FFS members, and Chapter 1100 for FESP members. The following services and procedures are covered only under emergency circumstances:

1. Emergency oral diagnostic examination (limited oral examination – problem focused)

2. Radiographs and laboratory services, limited to the symptomatic teeth

3. Composite resin involving incisal angle due to recent tooth fracture

4. Prefabricated crowns, to eliminate pain due to recent tooth fracture only

5. Recementation of clinically sound inlays, crowns and fixed bridges

6. Pulp cap, direct plus protective filling

7. Vital pulpotomies performed on six (6) maxillary teeth and six (6) mandibular anterior teeth only

8. Apicoectomy performed as a separate procedure on anterior teeth, for treatment of acute infection or to eliminate pain, with favorable prognosis

9. Immediate and palliative procedures, including extractions if medically necessary, for relief of severe pain associated with an oral or maxillofacial condition

10. Tooth reimplantation of accidentally avulsed or displaced anterior tooth, with favorable prognosis

11. Temporary restoration which provides palliative/sedative care (limited to the tooth receiving emergency treatment)

12. Initial treatment for acute infection, including, but not limited to, perapical and periodontal infections and abscesses by appropriate methods

13. Immediate and palliative procedures for acute craniomandibular problems and for traumatic injuries to teeth, bone or soft tissue, and

14. Preoperative procedures and anesthesia appropriate for optimal patient management.

Prior authorization from the AHCCCS Division of Fee for Service Management is not required for emergency dental procedures provided to FFS members.

Medically Necessary Dentures - AHCCCS covers partial or complete dentures, and related services when determined to be medically necessary by the primary care provider (PCP) in conjunction with the member's attending dentist, to alleviate the member's health problem. The PCP and attending dentist must provide documentation which clearly shows that dentures are medically necessary for the ongoing and continued health of the member. Neither the inability to properly masticate nor cosmetic considerations, alone or in combination, constitute medical necessity for dentures.

The following circumstances should be considered when determining coverage of dentures or for the replacement of dentures for members who are edentulous or partially edentulous:

1. The member's existing dentures are no longer serviceable and cannot be relined or rebased

2. The member's health would be adversely affected by the absence of prosthesis

3. The member has been able to wear dentures successfully in the past and has not gone more than six months without wearing a prosthetic replacement

4. If partial dentures are recommended, they must be deemed essential for function. As a standard, it may be considered that six posterior teeth in occlusion (three maxillary and three mandibular teeth in functional contact with each other) will be considered adequate for functional purposes. Abutment teeth must be free of decay and periodontally sound.

5. Denture repair will be approved only if it is essential to the serviceability of the appliance.

Limitations to the Coverage of Dentures

1. Radiographs are limited to use as a diagnostic tool preceding treatment of symptomatic teeth and to support the need for, and provision of, dentures

2. Provision of dentures for cosmetic purposes is not a covered service

3. Extraction of asymptomatic teeth is not a covered service, unless their removal is medically necessary and constitutes the most cost-effective dental procedure for the provision of medically necessary dentures.

Limitations to the Coverage of Emergency Dental Services

1. Maxillofacial dental services provided by a dentist are not covered except to the extent prescribed for the reduction of trauma, including reconstruction of regions of the maxilla and mandible

2. Diagnosis and treatment of temporomandibular joint dysfunction are not covered except for the reduction of trauma

3. Routine restorative procedures and routine root canal therapy are not emergency services

4. Treatment for the prevention of pulpal death and imminent tooth loss is limited to non-cast fillings, crowns constructed from pre-formed stainless steel, pulp caps, and pulpotomies only for the tooth causing pain or in the presence of active infection

5. Root canals are limited to six (6) maxillary anterior teeth and six (6) mandibular teeth, and only when indicated as treatment for acute infection or to eliminate pain.

Dental Services for Members Eligible for Transplantation Services - AHCCCS covers dental diagnosis and elimination of oral infection prior to transplantation of organs or tissues only after the member has been established as an otherwise appropriate candidate for transplantation. Refer to the transplantation section of this policy for additional information regarding specific transplantation services.

- **DIALYSIS**

Description. AHCCCS covers hemodialysis and peritoneal dialysis services provided by participating Medicare certified hospitals and Medicare certified End Stage Renal Disease facilities. All services, supplies, diagnostic testing (including routine medically necessary laboratory tests) and drugs medically necessary for the dialysis treatment are covered.

Amount, Duration and Scope. Medically necessary outpatient dialysis treatments are covered. Inpatient dialysis treatments are covered when the hospitalization is for:

1. Acute medical condition requiring dialysis treatments (hospitalization related to dialysis)

2. AHCCCS covered medical condition requiring inpatient hospitalization experienced by a member routinely maintained on an outpatient chronic dialysis program, or

3. Placement, replacement or repair of the chronic dialysis route.

NOTE: Hospital admissions solely to provide chronic dialysis are not covered.

NOTE: Hemoperfusion is covered when medically necessary.

Refer to Chapter 1100 for policy related to dialysis coverage within the Federal Emergency Services Program (FESP).

- **EMERGENCY MEDICAL SERVICES**

Description. As specified in A.A.C. R9-22-210, AHCCCS covers emergency medical services for managed care and FFS members who are not in the Federal Emergency Services Program (FESP). Refer to Chapter 1100 for all requirements regarding FESP.

Emergency medical services are provided for the treatment of an emergency medical condition. An emergency medical condition is a medical condition, including labor and delivery, which manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonable expect the absence of immediate medical attention to result in:

1. Placing the member's health in serious jeopardy

2. Serious impairment of bodily functions, or

3. Serious dysfunction of any bodily organ or part.

Amount, Duration and Scope. Emergency medical services are covered for members when there is a demonstrated need, and/or after triage/emergency medical assessment services indicate an emergency condition.

A provider is not required to obtain prior authorization for emergency services. Regarding emergency services, refer to Exhibit 310-1 for a reprint of A.A.C. R9-22-210 that describes general provisions for responsible entities, payment and denial of payment, notification requirements and post-stabilization requirements.

Utilization of emergency services. Managed care Contractors must educate their members regarding the appropriate utilization of emergency room services. Members should be encouraged to obtain services from non-emergency facilities (e.g., urgent care centers) to address member non-emergency care after regular office hours or on weekends.

Refer to Chapter 500 for the policy regarding member transfers after an emergency hospitalization.

Refer to Chapter 800 for additional information regarding emergency medical services for FFS members who are not in FESP.

Refer to Chapter 1100 for a complete discussion of covered emergency medical services under the FESP.

Refer to A.A.C. R9-22-217 and Chapter 1100 of this Manual for a complete discussion of covered emergency medical services under the FESP.

- **EYE EXAMINATIONS/OPTOMETRY SERVICES**

Description. AHCCCS covers eye and optometric services provided by qualified eye/optometry professionals within certain limits based on member age and eligibility.

Amount, Duration and Scope. Emergency eye care which meets the definition of an emergency medical condition is covered for all members. For members who are 21 years of age or older, treatment of medical conditions of the eye, excluding eye examinations for prescriptive lenses and the provision of prescriptive lenses, are covered. Vision examinations and the provision of prescriptive lenses are covered for members under the Early and Periodic Screening, Diagnosis and Treatment Program, KidsCare Program and for adults when medically necessary following cataract removal. Refer to Chapter 400 for detailed information regarding coverage of eye exams and prescriptive lenses for children.

Cataract removal is covered for all eligible members. Cataract removal is a covered service when the cataract is visible by exam, ophthalmoscopic or slit lamp, and any of the following apply:

1. Visual acuity that cannot be corrected by lenses to better than 20/70 and is reasonably attributable to cataract

2. In the presence of complete inability to see posterior chamber, vision is confirmed by potential acuity meter reading, or

3. For FFS members, who have corrected visual acuity between 20/50 and 20/70, a second opinion by an ophthalmologist to demonstrate medical necessity may be required. Refer to the Contractors regarding requirements for their enrolled members.

Cataract surgery is covered only when there is a reasonable expectation by the operating ophthalmic surgeon that the member will achieve improved visual functional ability when visual rehabilitation is complete.

Cataract surgeries are generally done on an outpatient basis, but an inpatient stay may be required due to the need for complex medical and nursing care, multiple ocular conditions or procedures, or the member's medical status. Admission to the hospital may be deemed safer due to age, environmental conditions or other factors.

Other cases that may require medically necessary ophthalmic services include, but are not limited to:

1. Phacogenic Glaucoma, and

2. Phacogenic Uveitis.

Refer to Chapter 800 for prior authorization requirements for FFS providers.

- **HEALTH AND BEHAVIOR INTERVENTION**

Description. Health and behavioral assessment procedures (CPT codes 96150-96155) are used to identify and treat the psychological, behavioral, emotional, cognitive and social factors important to the prevention, treatment and management of physical health problems. The focus of the assessment is not on mental health, but on the stresses, expectations, lifestyle and perceptions that are associated with the underlying medical condition.

Amount, Duration and Scope. AHCCCS covers medically necessary health and behavioral assessment procedures (CPT codes 96150-96155). Interventions must be short-term interventions focused on physical health problems. The medical condition must be the primary basis for the intervention.

Individuals requiring the service(s) described above must not be referred to the Regional Behavioral Health Authorities (RBHAs).

The following professionals are approved by AHCCCS to provide health and behavioral assessments/interventions:

1. Psychologist
2. Licensed clinical social worker
3. Licensed marriage and family therapist
4. Licensed professional counselor, and
5. Psychiatric nurse practitioner.

Health and behavior intervention services may be performed in the following settings:

1. Federally Qualified Health Clinic (FQHC)
2. Rural Health Clinic

3. Office
4. The member's home
5. Indian Health Service (IHS) Freestanding Facility
6. IHS Provider Based Facility
7. Tribal 638 Freestanding Facility, and
8. Tribal 638 Provider Based Facility.

Limitations.

1. Services are limited to 48 units annually (unit is equal to 15 minutes), and
2. Services are limited to the providers and settings listed above.

- **HEALTH RISK ASSESSMENT AND SCREENING TESTS**

Description. AHCCCS covers health risk assessment and screening tests provided by a physician, primary care provider or other licensed practitioner within the scope of his/her practice under State law for all members. These services include appropriate clinical heath risk assessments and screening tests, immunizations, and health education, as appropriate for age, history and current health status.

Health risk assessment and screening tests are also covered for members under the Early and Periodic Screening, Diagnosis and Treatment Program and KidsCare Program. Refer to Chapter 400 for complete details.

Amount, Duration and Scope. Preventive health risk assessment and screening test services for non-hospitalized adults include, but are not limited to:

1. Hypertension screening (annually)
2. Cholesterol screening (once, additional tests based on history)
3. Routine mammography annually after age 50 and at any age if considered medically necessary
4. Cervical cytology (annually for sexually active women, after three successive normal exams the test may be less frequent)
5. Colon cancer screening (digital rectal exam and stool blood test, annually after age 50)
6. Sexually transmitted disease screenings (at least once during pregnancy, other based on history)
7. Tuberculosis screening (once, with additional testing based on history, or, for AHCCCS members residing in a facility, as necessary per health care institution licensing requirement)
8. HIV screening

9. Immunizations (refer to separate section within this policy)

10. Prostate screening (annually after age 50, screening is recommended annually for males 40 and older who are at high risk due to immediate family history), and

11. Physical examinations, periodic health examinations or assessments, diagnostic work ups or health protection packages designed to: determine risk of disease, provide early detection of disease, detect the presence of injury or disease, establish a treatment plan, evaluate the results or progress of treatment plan or the disease, or to establish the presence and characteristics of a physical disability which may be the result of disease or injury.

Screening services provided more frequently than these professionally recommended guidelines will not be covered unless medically necessary.

Physical examinations not related to covered health care services or performed to satisfy the demands of outside public or private agencies such as the following are not covered services:

1. Qualification for insurance

2. Pre-employment physical examination

3. Qualifications for sports or physical exercise activities

4. Pilots examinations (Federal Aviation Administration)

5. Disability certification for the purpose of establishing any kind of periodic payments, or

6. Evaluation for establishing third party liability.

The AHCCCS Division of Fee-for-Service Management does not require prior authorization for medically necessary health risk assessment and screening services performed by fee-for-service providers.

- **HOME HEALTH SERVICES**

Description. AHCCCS covers medically necessary home health services provided in the member's place of residence as a cost effective alternative to hospitalization. Covered services, within certain limits, include: home health nursing visits, home health aide services, medically necessary supplies and therapy services in accordance with Arizona Revised Statutes 36-2907 for AHCCCS members.

ALTCS covers home health services for members who are either elderly and/or have physical disabilities (E/PD) and/or members with developmental disabilities receiving home and community based services. Refer to Chapter 1200 for additional information.

Amount, Duration and Scope. Home health nursing and home health aide services are provided on an intermittent basis as prescribed by a primary care provider or treating physician in accordance with 9 A.A.C. 10, Article 11, Home Health Agencies. Physical therapy services provided by a licensed home health agency (HHA) are covered for acute care, Early and Periodic Screening, Diagnosis and Treatment (EPSDT), KidsCare and ALTCS members. Speech and occupational therapy services provided by a licensed HHA are covered for EPSDT and ALTCS members only.

Refer to Chapter 800 for prior authorization requirements for FFS providers.

- **RESERVED**

- **HOSPITAL INPATIENT SERVICES**

Description. AHCCCS covers medically necessary inpatient hospital services provided by a licensed participating hospital for all eligible members, as specified in 9 A.A.C. 22, Article 2.

Amount, Duration and Scope. Inpatient hospital services for members include, but are not limited to, the following:

Hospital accommodation, and appropriate staffing, supplies, equipment and services for:

1. Routine acute medical care
2. Intensive care and coronary care
3. Neonatal intensive care
4. Maternity care including labor, delivery and recovery rooms, birthing centers, and nursery and related services
5. Nursery for newborns and infants
6. Surgery including surgical suites and recovery rooms, and anesthesiology services
7. Acute behavioral health emergency services
8. Nursing services necessary and appropriate for the member's medical condition
9. Dietary services, and/or
10. Medical supplies, appliances and equipment consistent with the level of accommodation.

Ancillary Services

1. Chemotherapy
2. Dental surgery for members in the Early and Periodic Screening, Diagnosis and Treatment Program
3. Dialysis
4. Laboratory services
5. Pharmaceutical services and prescribed drugs
6. Podiatry services performed by a podiatrist and ordered by a primary care provider
7. Radiological and medical imaging services
8. Rehabilitation services including physical, occupational and speech therapies
9. Respiratory therapy
10. Services and supplies necessary to store, process and administer blood and blood derivatives, and/or
11. Total parenteral nutrition.

AHCCCS covers semiprivate inpatient hospital accommodations, except when the member's medical condition requires isolation.

Refer to Chapter 800 for prior authorization requirements for FFS providers.

- **HYSTERECTOMY**

Description. AHCCCS covers medically necessary hysterectomy services.

Amount, Duration and Scope. AHCCCS does not cover a hysterectomy procedure if it is performed solely to render the individual permanently incapable of reproducing.

Coverage of hysterectomy services is limited to those cases in which medical necessity has been established by careful diagnosis, and, except for treatment of carcinoma and/or management of life-threatening hemorrhage, has been preceded by a trial of therapy (medical or surgical), which was proven unsatisfactory.

Hysterectomy services may be considered medically necessary without trial of therapy in the following cases:

1. Invasive carcinoma of the cervix
2. Ovarian carcinoma
3. Endometrial carcinoma
4. Carcinoma of the fallopian tube
5. Malignant gestational trophoblastic disease
6. Life-threatening uterine hemorrhage, uncontrolled by conservative therapy; or
7. Potentially life-threatening hemorrhage as in cervical pregnancy, interstitial pregnancy, or placenta abruptio.

In other cases, medical necessity for a hysterectomy is established by failure of more conservative medical and surgical therapy. For example:

1. Dysfunctional Uterine Bleeding or Benign Fibroids associated with Dysfunctional Bleeding: A hysterectomy should be confined to members for whom medical and surgical therapy has failed and childbearing is no longer a consideration.

2. Endometriosis: A hysterectomy is indicated in members with severe disease when future child-bearing is not a consideration, or when disease is refractory to medical or surgical therapy

3. Uterine Prolapse: A hysterectomy can be indicated for the symptomatic parous member for whom childbearing is no longer a consideration and for whom non-operative and/or surgical correction, i.e., suspension, repair will not provide the member adequate relief.

The provider performing hysterectomy procedures must ensure the member is aware that the procedure will result in sterility. The member must signify by dated signature that she has been informed and understands the consequences of having a hysterectomy. This documentation must be kept in the member's medical record. A copy must also be kept in the member's medical record maintained by the primary care provider if enrolled with a Contractor.

The provider is not required to complete a Consent to Sterilization form prior to performing hysterectomy procedures and the 30 day waiting period required for sterilization does not apply to hysterectomy procedures.

Contractors may elect to use the sample hysterectomy consent form for fee-for-service (FFS) providers found in Chapter 800 (Exhibit 820-1) or they may elect to use other formats.

Refer to Chapter 800 for prior authorization requirements for FFS providers.

- **IMMUNIZATIONS**

Description. AHCCCS covers immunizations as appropriate for age, history and health risk, for adults and children.

AHCCCS follows recommendations as established by the Centers for Disease Control and Prevention (CDC) and the Advisory Committee on Immunization Practices (ACIP). Covered immunizations for adults include, but are not limited to:

1. Diphtheria-tetanus
2. Influenza
3. Pneumococcus
4. Rubella
5. Measles
6. Hepatitis-B, and
7. Pertussis, as currently recommended by the CDC or ACIP.

Covered immunizations for children are identified in Chapter 400.

Amount, Duration and Scope. Immunizations for passport or visa clearance are not covered by AHCCCS.

The AHCCCS Division of Fee-for-Service Management does not require prior authorization for medically necessary immunization services performed by FFS providers.

- **LABORATORY**

Description. AHCCCS covers medically necessary laboratory services prescribed by a primary care provider, other practitioner or dentist which are ordinarily provided in Clinical Laboratory Improvement Act (CLIA) approved hospital, independent clinic, physician's office and other health care facility laboratories for all eligible members as defined in 9 A.A.C. 22, Article 2.

Amount, Duration and Scope. Medically necessary diagnostic testing and screening are covered services.

Refer to the AHCCCS FFS Provider Manual for information regarding CLIA requirements for AHCCCS covered laboratory services. This manual is available on the AHCCCS Web site (www.azahcccs.gov).

The AHCCCS Division of FFS Management does not require prior authorization for medically necessary laboratory services performed by FFS providers.

- **MATERNAL AND CHILD HEALTH SERVICES**

  Description. AHCCCS covers a comprehensive set of services for pregnant women, newborns and children, including maternity care, family planning services and services provided through the Early and Periodic Screening, Diagnosis and Treatment Program.

  Refer to Chapter 400 for a complete discussion of covered maternal and child health services.

- **MEDICAL SUPPLIES, DURABLE MEDICAL EQUIPMENT AND ORTHOTIC/PROSTHETIC DEVICES**

Description. AHCCCS covers reasonable and medically necessary medical supplies, durable medical equipment (DME) and orthotic/prosthetic devices when prescribed by a primary care provider, a practitioner or by a dentist within certain limits based on member age and eligibility, as specified in 9 A.A.C. 22, Article 2. For the purposes of this policy, DME means sturdy, long lasting items and appliances that can withstand repeated use, are designed to serve a medical purpose and are not generally useful to a person in the absence of a medical condition, illness or injury.

DME and devices are used to assist members in optimizing their independence and maintaining placement in the most integrated setting. This may include an institutional setting as appropriate. An example for the institutional setting is the authorization of customized medical devices such as wheelchairs. Criteria for the authorization of a customized wheelchair must be the same regardless of setting as each setting is considered the member's home.

Amount, Duration and Scope. Covered medical supplies, durable medical equipment and orthotic/prosthetic devices include, but are not limited to:

1. Medical supplies - surgical dressings, splints, casts and other consumable items, which are not reusable, and are designed specifically to meet a medical purpose

2. Durable equipment - wheelchairs, walkers, hospital beds, bedpans and other durable items that are rented or purchased, and

3. Orthotic/prosthetic devices which are essential to the rehabilitation of the member.

The Contractor must make timely determinations of coverage. The Contractor shall not refuse to render a timely determination based on the member's dual eligibility status or the providers' contract status with the Contractor. If a dual eligible member resides in a nursing facility, the prior authorization request must not be denied on the basis that Medicare is responsible for coverage of DME.

The following criteria must be used in determining coverage:

1. Medical necessity in setting up and/or maintaining the member in the most appropriate setting while maximizing the member's independence and functional level both physically and mentally, and

2. The most reasonable and cost effective alternative to provide medically necessary services in the most appropriate setting and maximizing the member's independence.

Medical equipment may be purchased or rented only when there are no reasonable alternative resources from which the medically necessary medical equipment can be obtained at no cost. Total expense of rental will not exceed the purchase price of the item.

Rental fees must terminate no later than the end of the month in which the member no longer needs the medical equipment, or when the member is no longer eligible or enrolled with a Contractor, except during transitions as specified by the AHCCCS Chief Medical Officer.

Reasonable repairs or adjustment of purchased medical equipment is covered when necessary to make the equipment serviceable and when the cost of the repair is less than the cost of rental or purchase of another unit.

AHCCCS **does not** cover the following medical supplies, durable medical equipment, and orthotic/prosthetic devices:

1. Incontinent supplies (unless determined medically necessary). Refer to Chapter 400, Policy 430, for criteria related to coverage of incontinence briefs for members under age 21.

2. Personal incidentals including items for personal cleanliness, body hygiene and grooming (except to treat a medical condition under a prescription)

3. First aid supplies (except under a prescription)

4. Hearing aids for members who are 21 years of age and older

5. Prescriptive lenses for members who are 21 years of age and older (except if medically necessary following cataract removal), and/or

6. Penile implants or vacuum devices for AHCCCS members who are 21 years of age or older.

Refer to Chapter 800 for prior authorization requirements for FFS providers.

Refer to Chapter 1200 for further information related to ALTCS.

- **NON-PHYSICIAN SURGICAL FIRST ASSISTANT SERVICES**

Description. AHCCCS will cover services provided by non-physician surgical first assistants who are licensed in Arizona as a physician's assistant or registered nurse, and who are registered as an AHCCCS provider to render non-physician surgical first assistant services. The provider must furnish documentation of compliance with the following requirements:

1. Each non-physician surgical first assistant provider must have the sponsorship of an Arizona-licensed physician, and receive supervision from the physician as required under their scope of practice.

2. Non-physician surgical first assistant services must be provided under the supervision of a physician surgeon licensed to practice in Arizona and registered with AHCCCS as a provider.

3. Providers of non-physician surgical first assistant services must hold liability insurance which meets or exceeds limits required for AHCCCS registration.

4. Providers must be currently certified in advanced cardiac life support and CPR, and

5. Non-physician surgical first assistants must be:

    a. Currently licensed in Arizona either as a registered nurse with current Registered Nurse First Assistant certification (CRNFA) by the National Certification Board of Perioperative Nursing (AORN approved), or as a nurse practitioner with appropriate surgical first assistant training, or

    b. Currently licensed in Arizona to practice as a physician's assistant. Physician's assistants must provide services under the supervision of their supervising physician or a supervising physician agent who has been approved by the Arizona Joint Board on the Regulation of Physician Assistants as stipulated within their scope of practice and required by law.

Amount, Duration and Scope. The non-physician surgical first assistant is governed by professional guidelines as determined by their licensing and/or certifying agency and the medical staffing bylaws of the facility where services are provided. Any non-physician surgical first assistant who has had his/her professional license suspended or revoked is ineligible for registration for this provider type or AHCCCS coverage for services.

• NURSING FACILITY (NF) SERVICES

Description. AHCCCS covers medically necessary services provided in nursing facilities for those acute care program members who need nursing care 24 hours a day, but who do not require hospital care under the daily direction of a physician. NF service providers must be State licensed and Medicare certified. Religious nonmedical health care institutions are exempt from licensure or certification requirements.

The Arizona Long Term Care System (ALTCS) offers more extensive coverage of NF services for members. Refer to Chapter 1200 for information regarding ALTCS covered services. In lieu of NF services, the member may be placed in an alternative home and community based setting (HCBS), or may receive home and community based services in their home, as defined in the Arizona Administrative Code R9-22, Article 2 and R9-28, Article 2.

Amount, Duration and Scope. AHCCCS covers up to 90 days of NF services per contract year (generally October 1 through September 30) for members who have not been determined eligible for ALTCS.

- The medical condition of the member must be such that if NF services are not provided, hospitalization of the individual will result or the treatment is such that it cannot be administered safely in a less restrictive setting, i.e., home with home health services.

- The 90 days of coverage is per member, per contract year, and does not begin again if the member transfers to a different NF. Acute care members residing in a NF at the beginning of a new contract year begin a new 90-day coverage period. Unused days do not carry over. See the table below for examples.

- The 90 days of AHCCCS acute care coverage for NF services begins on the day of admission regardless of whether the member is insured by a third party insurance carrier, including Medicare. (Refer to the AHCCCS Contractor Operations Manual, Policies 201 and 202 regarding member cost sharing.)

If the member has applied for ALTCS and a decision is pending, the acute care Contractor must notify the ALTCS Eligibility Administrator (Mail Drop 2600) when the member has been residing in a NF for 75 days. This will allow for time to follow-up on the status of the ALTCS application. If the member becomes ALTCS eligible and is enrolled with an ALTCS Contractor before the end of the maximum 90 days of NF coverage, the acute care Contractor is only responsible for NF coverage during the time the member is enrolled with the acute care Contractor. The NF must coordinate with the member or representative on alternative methods of payment for continuation of services beyond the 90 days covered by the acute care Contractor until the member is enrolled in the ALTCS program, or until the beginning of the new contract year.

Member A	Admitted January 15	Discharged April 3	79 days. 11 days of NF services remain available through September 30.
Member B	Admitted January 15	Still in NF April 14	90 days. NF should have contacted member's Contractor at least 15 days before to discuss alternatives. Contractor should have contacted AHCCCS by Day 75 regarding ALTCS application.
Member C	Admitted July 3	Still in NF September 30	89 days, but new contract year begins October 1. 90 days begin again.

NOTE: For most, but not all, AHCCCS Contractors, the contract year runs from October 1 through September 30. Providers should contact the member's Contractor for verification of contract dates and any discussion needed regarding the member's stay.

Services that are not covered separately by Acute Care or ALTCS Contractors when provided in a NF include:

1. Nursing services, including:

    a. Administration of medication

    b. Tube feedings

    c. Personal care services

    d. Routine testing of vital signs and blood glucose monitoring

e. Assistance with eating, and/or

f. Maintenance of catheters.

2. Basic patient care equipment and sickroom supplies such as bedpans, urinals, diapers, bathing and grooming supplies, walkers and wound dressings or bandages

3. Dietary services including, but not limited to, preparation and administration of special diets, and adaptive tools for eating

4. Administrative physician visits made solely for the purpose of meeting State certification requirements

5. Non-customized durable equipment and supplies such as: wheelchairs, geriatric chairs, and bedside commodes

6. Rehabilitation therapies prescribed as a maintenance regimen

7. Administration, Medical Director services, plant operations and capital

8. Over-the-counter medications and laxatives

9. Social activity, recreational and spiritual services, or

10. Any other services, supplies or equipment that are State or County regulatory requirements or are included in the NF's room and board charge.

Refer to Chapter 800 for PA requirements for FFS providers.

- **OBSERVATION SERVICES**

Description. Observation services are those reasonable and necessary services provided on a hospital's premises for evaluation to determine whether the member should be admitted for inpatient care, discharged or transferred to another facility. Observation services include: the use of a bed, periodic monitoring by a hospital's nursing or, if appropriate, other staff necessary to evaluate, stabilize or treat medical conditions of a significant degree of instability and/or disability on an outpatient basis.

It is not observation status when a member with a known diagnosis enters a hospital for a scheduled procedure/treatment that is expected to keep the member in the hospital for less than 24 hours. (This is an outpatient procedure, regardless of the hour in which the member presented to the hospital, whether a bed was utilized or whether services were rendered after midnight.)

Extended stays after outpatient surgery must be billed as recovery room extensions.

Observation services must be provided in a designated "observation area" of the hospital unless such an area does not exist.

Amount, Duration and Scope. Observation status must be ordered in writing by a physician, or other individual authorized by hospital staff bylaws, to admit patients to the hospital or to order outpatient diagnostic tests or treatments. Observation status should not exceed 24 hours. If the 24 hour time limit is exceeded in order to complete evaluation of the medical condition and/or treatment of a member, AHCCCS notification is required for coverage.

Factors that must be taken into consideration by the physician or authorized individual when ordering observation status:

1. Severity of the signs and symptoms of the member

2. Degree of medical uncertainty that the member may experience an adverse occurrence

3. Need for diagnostic studies that appropriately are outpatient services (i.e., their performance does not ordinarily require the member to remain at the hospital for 24 hours or more) to assist in assessing whether the member should be admitted

4. The availability of diagnostic procedures at the time and location where the member presents

5. It is reasonable, cost effective and medically necessary to evaluate a medical condition or to determine the need for inpatient admission, and

6. Length of stay for observation status is medically necessary for the member's condition.

The following services are not AHCCCS covered observation services:

1. Substitution of outpatient services provided in observation status for physician ordered inpatient services

2. Services that are not reasonable, cost effective and necessary for diagnosis or treatment of member

3. Services provided solely for the convenience of the member or physician

4. Excessive time and/or amount of services medically required by the condition of the member

5. Services customarily provided in a hospital-based outpatient surgery center and not supported by medical documentation of the need for observation status.

Medical Record Documentation of Observation Status

The following are required for documenting medical records:

1. Orders for observation status must be written on the physician's order sheet, not the emergency room record, and must specify, "admit to observation." Rubber stamped orders are not acceptable

2. Follow-up orders must be written within the first 24 hours, and at least every 24 hours if observation status is extended.

3. Changes from "observation status to inpatient" or "inpatient to observation status" must be made per physician order.

4. Inpatient to observation status must be made by a physician or authorized individual and occur within 12 hours after admission as an inpatient, and

5. Inpatient/outpatient status change must be supported by medical documentation.

Refer to Chapter 800 for prior authorization and utilization management requirements for FFS providers.

- **PHYSICIAN SERVICES**

Description. AHCCCS covers physician services for all members within certain limits based on member age and eligibility. Physician services include medical assessment, treatment, and surgical services performed in the office, clinic, hospital, home, nursing facility or other location by a licensed doctor of medicine or osteopathy.

Amount, Duration and Scope. Physician services are covered as appropriate to the member's medical need and the physician's scope of practice.

Complete physical examinations for new members to determine risk of disease, provide early detection and to establish a prevention or treatment plan for the member, and annual periodic examinations to monitor health status are covered.

AHCCCS does not cover physician services routinely performed and not directly related to the medical care of a member (e.g., physician visits to an NF for the purpose of 30-60 day certification).

AHCCCS does not cover moderate sedation (i.e., conscious sedation) performed by the physician performing the underlying procedure for which sedation is desired, or by another provider except as described below, for the adult population. Refer to Chapter 400, Policy 430, for criteria related to coverage of conscious sedation for members under the age of 21.

AHCCCS does cover monitored anesthesia care, including all levels of sedation, provided by qualified anesthesia personnel (physician anesthesiologist or certified registered nurse anesthetist) for the adult population and members under the age of 21.

Refer to Chapter 800 for prior authorization requirements for FFS providers.

- **PODIATRY SERVICES**

Description. AHCCCS covers medically necessary podiatry services when ordered by a member's primary care provider, attending physician or practitioner, within certain limits, for eligible members. Services must be provided by a licensed podiatrist in compliance with A.A.C. Title 4, Chapter 25.

Amount, Duration and Scope. Coverage includes medically necessary routine foot care, limited bunionectomy services, casting for the purpose of constructing or accommodating orthotics, medically necessary orthopedic shoes or shoes that are an integral part of a brace. Routine foot care is not covered except as noted in this policy.

For purposes of this policy, routine foot care includes the cutting or removal of corns or calluses; the trimming of nails (including mycotic nails) and other hygienic and preventive maintenance care in the realm of self-care, such as cleaning and soaking the feet, the use of skin creams to maintain skin tone of both ambulatory and bedfast patients and any services performed in the absence of localized illness, injury or symptoms involving the foot. Such routine foot care is generally not deemed medically necessary and therefore is usually not covered by AHCCCS.

When the patient has a systemic disease of sufficient severity that performance of routine foot care procedures by a nonprofessional person would be hazardous, then procedures ordinarily considered routine foot care are covered as medically necessary foot care. Conditions that might necessitate medically necessary foot care include metabolic, neurological and peripheral vascular systemic diseases. Examples include, but are not limited to:

1. Arteriosclerosis obliterans (arteriosclerosis of the extremities, occlusive peripheral arteriosclerosis)

2. Buerger's disease (thromboangiitis obliterans)

3. Chronic thrombophlebitis

4. Diabetes mellitus

5. Peripheral neuropathies involving the feet

6. Member receiving chemotherapy

7. Pernicious Anemia

8. Hereditary disorder, i.e., hereditary sensory radicular neuropathy, Fabry's disease

9. Hansen's disease or neurosyphilis

10. Malabsorption syndrome

11. Multiple sclerosis

12. Traumatic injury

13. Uremia (chronic renal disease)

14. Patient on anticoagulants.

Treatment of a fungal (mycotic) infection is considered medically necessary foot care and is covered in the following circumstances:

1. A systemic condition, and

2. Clinical evidence of mycosis of the toenail, and

3. Compelling medical evidence documenting the member either:

   (a) has a marked limitation of ambulation due to the mycosis which requires active treatment of the foot, or

   (b) in the case of a nonambulatory member, has a condition that is likely to result in significant medical complications in the absence of such treatment.

Limitations.

1. Coverage for routine foot care must not exceed two visits per quarter or eight visits per contract year (this does not apply to Early and Periodic Screening, Diagnosis and Treatment [EPSDT] members).

2. Coverage of mycotic nail treatments will not exceed one bilateral mycotic nail treatment (up to ten nails) per 60 days (this does not apply to EPSDT members).

3. Neither general diagnoses such as arteriosclerotic heart disease, circulatory problems, vascular disease, venous insufficiency or incapacitating injuries or illnesses such as rheumatoid arthritis, CVA (stroke) or fractured hip are diagnoses under which routine foot care is covered.

Bunionectomy - Bunionectomies are covered only when the bunion is present with:

1. Overlying skin ulceration, or

2. Neuroma secondary to bunion (neuroma to be removed at same surgery and documented by pathology report).

Bunionectomies are not covered if the sole indications are pain and difficulty finding appropriate shoes.

Refer to Chapter 800 for prior authorization requirements for FFS providers.

- **PRESCRIPTION MEDICATIONS/PHARMACY SERVICES**

Description. Prescription medications prescribed by a primary care provider, physician, other practitioner or a dentist and provided by a licensed pharmacy or dispensed under the direct supervision of a licensed pharmacist are covered for members, as defined in 9 A.A.C. 22, Article 2.

Amount, Duration and Scope. The following services are not covered:

1. An over-the-counter medication, in place of a covered prescription medication, is covered only if the over-the-counter medication is appropriate, equally effective, safe and less costly than the covered prescription medication.

2. Medications for the treatment of sexual or erectile dysfunction, unless used to treat a condition other than sexual or erectile dysfunction for which the medications have been approved by the Food and Drug Administration.

3. Medications personally dispensed by a physician or dentist, except in geographically remote areas where there is no participating pharmacy or when accessible pharmacies are closed

4. Drugs included in the "Drug Efficacy Study Implementation" which are designated as ineffective, and

5. Outpatient medications are not covered under the Federal Emergency Services Program.

Limitations for prescription drug coverage include:

1. A prescription or refill in excess of a 30-day supply or a 100-unit dose is not covered unless:

    a. The medication is prescribed for chronic illness and the prescription is limited to no more than a 100-day supply or 100-unit dose, whichever is greater

b. The member will be out of the provider's service area for an extended period of time and the prescription is limited to the extended time period, not to exceed 100 days or 100-unit dose, whichever is greater, and/or

c. The medication is prescribed for contraception and the prescription is limited to no more than a 100-day supply.

1. Prescription drugs for covered transplantation services will be provided in accordance with AHCCCS transplantation policies.

2. Effective January 1, 2006, with implementation of the Part D prescription drug benefit of the Medicare Prescription Drug Improvement and Modernization Act of 2003, for Medicaid members enrolled or eligible for Medicare Part D prescription drug benefits, AHCCCS continues to cover:

   a. Medically necessary barbiturates and benzodiazepines not covered by a Part D plan, and

   b. Non-prescription drugs not required as part of a Part D plan stepped-therapy program that are appropriate and less costly than the covered prescription drug. See Amount, Duration and Scope (#1) above.

4. Contractors may limit covered prescription drugs by developing formularies.

Return of and Credit for Unused Medications

Effective April 1, 2006, in accordance with the Deficit Reduction Act of 2005, AHCCCS and its Contractors shall require the appropriate return of and payment credit for unused prescription medications from nursing facilities (NFs) upon discontinuance of the prescription, or the transfer, discharge or death of the Medicaid member, or from other outpatient pharmacies. The pharmacy may charge a reasonable restocking fee.

Such return of unused prescription medication shall be in accordance with Federal and State laws. Arizona Administrative Code (A.A.C. R4-23-409) allows this return and redistribution under certain circumstances. Documentation must be maintained of the quantity of medications dispensed and consumed by the member and a credit issued to AHCCCS (if the member is FFS) or the member's Contractor when the unused medication is returned to the pharmacy for redistribution.

Refer to Section 1903(i)(10) of the Social Security Act as amended by Section 6033 of the Deficit Reduction Act of 2005, the CMS State Medicaid Director Letter dated March 22, 2006, and A.A.C. R4-23-409.

Refer to Chapter 800 for prior authorization requirements for FFS providers.

- **RADIOLOGY AND MEDICAL IMAGING**

Description. AHCCCS covers radiology and medical imaging services for all eligible members when prescribed by a primary care provider, other practitioner or dentist for diagnosis, prevention, treatment or assessment of a medical condition, as defined in 9 A.A.C Chapter 22, Article 2. Settings for the provision of services include hospitals, clinics, physician offices and other health care facilities.

Amount, Duration and Scope. The AHCCCS acute care program covers medically necessary radiology and imaging services.

The AHCCCS Division of FFS Management does not require prior authorization for medically necessary radiology and medical imaging services performed by FFS providers.

- **REHABILITATION THERAPIES (OCCUPATIONAL, PHYSICAL AND SPEECH)**

Description. AHCCCS covers occupational, physical and speech therapy services that are ordered by a primary care provider (PCP), or attending physician for FFS members, approved by AHCCCS Division of Fee-for-Service Management (DFSM) or the Contractor, and provided by or under the direct supervision of a licensed therapist as noted in this section.

Amount, Duration and Scope. The scope, duration and frequency of each therapeutic modality must be prescribed by the PCP/attending physician as part of the rehabilitation plan. The condition for which occupational, physical and speech therapy services are prescribed must be acute and the member must have the potential for improvement due to rehabilitation.

Refer to Chapter 800 for prior authorization requirements for FFS providers.

Refer to Chapter 1200 for additional information regarding ALTCS covered rehabilitation services.

Refer to Chapter 1200 for habilitation services.

OCCUPATIONAL THERAPY

Description. Occupational therapy (OT) services are medically prescribed treatments to improve or restore functions which have been impaired by illness or injury, or which have been permanently lost, or reduced by illness or injury. OT is intended to improve the member's ability to perform those tasks required for independent functioning.

Amount, Duration and Scope. AHCCCS covers medically necessary OT services provided to all members who are receiving inpatient care at a hospital (or a nursing facility) when services are ordered by the member's PCP/attending physician. Inpatient occupational therapy consists of evaluation and therapy.

Outpatient OT services are covered only for members receiving Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services, KidsCare members and ALTCS members.

OT services must be provided by a qualified occupational therapist licensed by the Arizona Board of Occupational Therapy Examiners or a certified OT assistant (under the supervision of the occupational therapist according to 4 A.A.C. 43, Article 4) licensed by the Arizona Board of Occupational Therapy Examiners. Occupational therapists who provide services to AHCCCS members outside the State of Arizona must meet the applicable State and/or Federal requirements.

Therapy services may include, but are not limited to:

1. Cognitive training
2. Exercise modalities
3. Hand dexterity
4. Hydrotherapy
5. Joint protection
6. Manual exercise
7. Measuring, fabrication or training in use of prosthesis, arthrosis, assistive device or splint
8. Perceptual motor testing and training
9. Reality orientation

10. Restoration of activities of daily living

11. Sensory reeducation, and

12. Work simplification and/or energy conservation.

PHYSICAL THERAPY

Description. Physical therapy (PT) is an AHCCCS covered treatment service to restore, maintain or improve muscle tone, joint mobility or physical function.

Amount, Duration and Scope. AHCCCS covers medically necessary physical therapy services for all members on an inpatient or outpatient basis. PT services must be rendered by a qualified physical therapist licensed by the Arizona Physical Therapy Board of Examiners or a Physical Therapy Assistant (under the supervision of the PT, according to 4 A.A.C. 24, Article 3) certified by the Arizona Physical Therapy Board of Examiners. Physical therapists who provide services to AHCCCS members outside the State of Arizona must meet the applicable State and/or Federal requirements.

Outpatient physical therapy is not covered as a maintenance regimen.

Authorized treatment services include, but are not limited to:

1. The administration and interpretation of tests and measurements performed within the scope of practice of PT as an aid to the member's treatment

2. The administration, evaluation and modification of treatment methodologies and instruction, and

3. The provision of instruction or education, consultation and other advisory services.

SPEECH THERAPY

Description. Speech therapy is the medically prescribed provision of diagnostic and treatment services that include evaluation, diagnostic and treatment services that include evaluation, program recommendations for treatment and/or training in receptive and expressive language, voice, articulation, fluency, rehabilitation and medical issues dealing with swallowing.

Amount, Duration and Scope. AHCCCS covers medically necessary speech therapy services provided to all members who are receiving inpatient care at a hospital (or a nursing facility) when services are ordered by the member's PCP or attending physician for FFS members. Speech therapy provided on an outpatient basis is covered only for members receiving EPSDT services, KidsCare and ALTCS members.

ST must be provided by:

1. A qualified speech-language pathologist licensed by the Arizona Department of Health Services (ADHS), or

2. A speech-language pathologist who has a temporary license from ADHS and is completing a clinical fellowship year. He/she must be under the direct supervision of an ASHA certified speech-language pathologist. AHCCCS registration will be terminated at the end of two years if the fellowship is not completed at that time.

3. Speech-language pathologists providing services to AHCCCS members outside the State of Arizona must meet the applicable State and/or Federal requirements.

Speech therapy provided on an outpatient basis is covered only for members receiving EPSDT services, KidsCare and ALTCS members.

Inpatient speech therapy consists of evaluation and therapy. Therapy services may include:

1. Articulation training

2. Auditory training

3. Cognitive training
4. Esophageal speech training
5. Fluency training
6. Language treatment
7. Lip reading
8. Non-oral language training
9. Oral-motor development, and
10. Swallowing training.

- **RESPIRATORY THERAPY**

Description. Respiratory therapy is an AHCCCS covered treatment service, prescribed by a primary care provider or attending physician for FFS members, to restore, maintain or improve respiratory functioning.

Services include administration of pharmacological, diagnostic and therapeutic agents related to respiratory and inhalation care procedures, observing and monitoring signs and symptoms, general behavioral and general physical response to respiratory care, diagnostic testing and treatment, and implementing appropriate reporting and referral protocols.

Amount, Duration and Scope. AHCCCS covers medically necessary respiratory therapy services for all members on both an inpatient and outpatient basis. Services must be provided by a qualified respiratory practitioner under A.R.S. §32-3501 (respiratory therapist or respiratory therapy technician), licensed by the Arizona Board of Respiratory Care Examiners. Respiratory practitioners providing services to AHCCCS members outside the State of Arizona must meet the applicable State and/or Federal requirements.

Refer to Chapter 1200 for ALTCS covered respiratory therapy services.

- **SLEEP STUDIES (POLYSOMNOGRAPHY)**

Description. AHCCCS covers inpatient and outpatient sleep studies performed in the settings described below.

Amount, Duration and Scope. Sleep studies are covered services in the following settings:

1. A licensed and certified hospital facility, or

2. A non-hospital facility that meets one of the following sets of criteria:

   a. Is licensed by the Arizona Department of Health Services (ADHS) and the facility is accredited by the American Academy of Sleep Medicine, or

   b. Has a Medical Director who is certified by the American Board of Sleep Medicine, and has a managing sleep technician who is registered by the Board of Registered Polysomnographic Technologists, or

   c. For sleep EEGs only, the facility must have a physician who is a Board certified neurologist. No ADHS license is required for this facility.

Limitations.

1. AHCCCS does not cover sleep studies performed in the home or in a mobile unit.

2. AHCCCS does not cover pulse oximetry alone as a sleep study.

- **TOTAL PARENTERAL NUTRITION (TPN)**

Description. TPN is the provision of total caloric needs by intravenous route for individuals with severe pathology of the alimentary tract which does not allow absorption of sufficient nutrients to maintain weight and strength appropriate for the individual's general condition. Nutrients are provided through an indwelling catheter.

Amount, Duration and Scope. AHCCCS follows Medicare guidelines for the provision of TPN services. TPN is covered for members over age 21 when it is medically necessary and the only method to maintain adequate weight and strength.

AHCCCS covers TPN for members receiving Early and Periodic Screening, Diagnosis and Treatment and KidsCare members when medically necessary and not necessarily the sole source of nutrition. Refer to Chapter 400 for complete information.

Refer to Chapter 800 for prior authorization requirements for FFS providers.

- **TRANSPORTATION**

AHCCCS covers transportation within certain limitations for all members based on member age and eligibility, as specified in the Arizona Administrative Code (A.A.C.) R9-22-211. Covered transportation services include:

1. Emergency transportation

2. Medically necessary transportation (non-emergency), and

3. Medically necessary maternal and newborn transportation.

The definitions relating to covered transportation services are as follows:

Air ambulance - Helicopter or fixed wing aircraft licensed under Arizona Department of Health Services (ADHS) as mandated by Arizona Revised Statutes to be used in the event of an emergency to transport members or to obtain services.

Ambulance - Motor vehicle licensed by ADHS pursuant to Arizona Revised Statutes especially designed or constructed, equipped and intended to be used, maintained and operated for the transportation of persons requiring ambulance services.

Description. Emergency Transportation - Emergency ground and air ambulance services required to manage an emergency medical condition of an AHCCCS member at an emergency scene and transport to the nearest appropriate facility are covered for all members. Emergency transportation is needed due to a sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could be expected to result in:

1. Placing the member's health in serious jeopardy

2. Serious impairment of bodily functions; or

3. Serious dysfunction of any bodily organ or part.

Emergency transportation may be initiated by an emergency response system call "9-1-1", fire, police, or other locally established system for medical emergency calls. Initiation of a designated emergency response system call by an AHCCCS member automatically dispatches emergency ambulance and EMT or Paramedic team services from the Fire Department. At the time of the call, emergency teams are required to respond; however, when they arrive on the scene, the services required at that time (based on field evaluation by the emergency team) may be determined to be:

1. Emergent

2. Nonemergent, but medically necessary, or

3. Not medically necessary.

Medically Necessary Transportation - AHCCCS covers medically necessary transportation as specified in A.A.C. R9-22-211.

Maternal and Newborn Transportation - The maternal transport program (MTP) and the newborn intensive care program (NICP) administered by the ADHS provides special training and education to designated staff in the care of maternity and newborn emergencies during transport to a perinatal center. The high risk transport team is dispatched after consultation with the MTP or NICP perinatologist or neonatologist. Only MTP or NICP Contractors may provide air transport.

Amount, Duration and Scope. Emergency transportation coverage is limited to those emergencies in which specially staffed and equipped ambulance transportation is required to safely manage the member's medical condition. Basic Life Support, Advanced Life Support, and air ambulance services are covered, depending upon the member's medical needs.

Emergency medical transportation includes the transportation of a member to a higher level of care for immediate medically necessary treatment, even after stabilization at an emergency facility. Emergency medical transportation is covered only to the nearest appropriate facility. The nearest appropriate facility for an AHCCCS fee-for-service (FFS) member is the nearest hospital medically equipped to provide definitive medical care. Contractor may establish preferred hospital arrangements, which must be communicated with emergency services providers. If the provider transports the member to the Contractor preferred hospital, the provider's claim must be honored even though that hospital may not be the nearest appropriate facility. However, the provider must not be penalized for taking the member to the nearest appropriate facility whether or not it is the Contractor preferred facility.

Acute conditions requiring emergency transportation to obtain immediate treatment include, but are not limited to the following:

1. Untreated fracture or suspected fracture of spine or long bones
2. Severe head injury or coma
3. Serious abdominal or chest injury
4. Severe hemorrhage
5. Serious complications of pregnancy
6. Shock, heart attack or suspected heart attack, stroke or unconsciousness
7. Uncontrolled seizures, and
8. Condition warranting use of restraints to safely transport to medical care.

For utilization review, the test for appropriateness of the request for emergency services is whether a prudent layperson, if in a similar situation, would have requested such services. (See Chapter 100 for the definition of prudent layperson.) Determination of whether a transport is an emergency is based on the member's medical condition at the time of transport.

Refer to the section of this policy regarding medically necessary transportation furnished by an ambulance provider for information related to transportation initiated by an emergency response system call.

Air ambulance services are covered under the following conditions:

1. The point of pickup is inaccessible by ground ambulance

2. Great distances or other obstacles are involved in getting the member to the nearest hospital with appropriate facilities; or

3. The medical condition of the member requires ambulance service and ground ambulance services will not suffice.

Air ambulance vehicles must meet ADHS licensing requirements and requirements set forth by the Federal Aviation Administration. Air ambulance companies must be licensed by the ADHS and be registered as a provider with AHCCCS.

Medically Necessary Transportation Furnished by Non-Emergency Transportation Providers:

Non-emergency medically necessary transportation is transportation, as specified in A.A.C. R9-22-211, and furnished by providers included therein, to transport the member to and from a required medical service. Such services may also be provided by emergency transportation providers after assessment by the EMT or Paramedic team that the member's condition requires medically necessary transportation.

Medically Necessary Transportation Furnished by Ambulance Providers:

Round-trip air or ground transportation services may be covered if an inpatient member goes to another facility to obtain necessary specialized diagnostic and/or therapeutic services (such as a CT scan or cobalt therapy). Such transportation may be covered if the following requirements are met:

1. Member's condition is such that the use of any other method of transportation is contraindicated

2. Services are not available in the hospital in which the member is an inpatient

3. Member returns to the point of origin, and

4. Hospital furnishing the services is the nearest one with such facilities, or the one specified by the member's Contractor.

Transportation services to the nearest medical facility that can render appropriate services are also covered, except as provided below, if the transport was initiated through an emergency response system call and, upon examination by emergency medical personnel, the patient's condition is determined to be non-emergent but one which requires medically necessary transportation. These services are covered by AHCCCS and do not require prior authorization (PA).

Maternal and Newborn Transportation - AHCCCS covers emergency transports of newborns to a level II or level III perinatal center from a lower level of care when a need for the higher level of care is determined to be immediate and medically necessary.

Transportation to a level II or level III perinatal center for diagnostic or elective services and back transports to the same or a lower level of care are not emergencies. Such medically necessary transports are subject to PA requirements of AHCCCS Division of Fee-for-Service Management (DFSM) or the Contractor.

Transportation Services Provided for AHCCCS Native American Members Who Are Enrolled with Indian Health Service (IHS).

Emergency Transportation Services: In addition to other requirements specified in this policy, emergency transportation providers rendering services on an Indian Reservation must meet the following requirements:

1. Tribal emergency transportation providers must be certified by the Tribe and CMS as a qualified provider and registered as an AHCCCS provider

2. If non-tribal emergency transportation providers render services under a contract with a Tribe either on-reservation or to and from an off-reservation location the provider must be State licensed and certified, and registered as an AHCCCS provider, or

3. Non-tribal transportation providers not under contract with a Tribe must meet requirements specified in this policy for emergency transport providers.

As with all emergency transportation, services are covered to manage an emergency medical condition at the emergency scene and in transport to the nearest appropriate facility.

Non-Emergency Medically Necessary Transportation Services to Obtain AHCCCS Covered Medical Services

1. For AHCCCS Native American members who reside either on-reservation or off-reservation and are enrolled with IHS (Contractor ID number 999998), transportation services are covered on a FFS basis (or if available, through 100% pass-through of Federal funds) under the following conditions:

    a. The medical service for which the transportation is needed is ordered by a licensed physician or other licensed practitioner and is a covered AHCCCS service

    b. The request for transportation services is initiated by an IHS referral form and prior authorized through AHCCCS DFSM

    c. The member is not able to provide, secure or pay for their own transportation, and free transportation is not available; and

    d. The transportation is provided to and from either of the following locations:

        (1) The nearest appropriate IHS medical facility located either on-reservation or off-reservation (facilities that are located out-of-state are subject to AHCCCS rules regarding reimbursement for out-of-state services), or

        (2) The nearest appropriate AHCCCS registered provider located off-reservation.

For Native American members residing off-reservation who are enrolled with a Contractor, all non-emergency medically necessary transportation is coordinated, authorized and provided through the Contractor.

Non-Emergency Medically Necessary Transportation Services to Obtain AHCCCS Covered Behavioral Health Services

Members who are enrolled with IHS and live either on-reservation or off-reservation, and are receiving behavioral health services as specified in this Chapter under Policy 310, Behavioral Health Services, may receive non-emergency medically necessary on-reservation transportation services as follows:

1. Non-emergency medically necessary transportation may be provided as outlined above (#1 of the Section addressing transportation to obtain medical services) on a FFS basis (or, if available, through 100% pass-through of Federal funds) for the following members:

    a. An IHS enrolled member, residing either on-reservation or off-reservation who is receiving behavioral health services but is not enrolled with an ADHS designated Regional Behavioral Health Authority (RBHA).

    b. An IHS enrolled member who lives on-reservation but is a member of a tribe that is not designated as a Tribal Behavioral Health Authority (TRBHA) through an agreement with the ADHS, and who receives services at an IHS facility or through an off-reservation provider; or

2. If the member is enrolled with, and receiving behavioral health services through, a RBHA or TRBHA, non-emergency medically necessary on-reservation transportation is coordinated, authorized and provided by the RBHA or TRBHA with reimbursement through ADHS.

Non-Emergency Medically Necessary Transportation Services to Obtain Arizona Long Term Care System Covered Services

All non-emergency medically necessary transportation for ALTCS FFS program members considered to be residing on an Indian reservation are covered and reimbursed through the AHCCCS Administration when authorized by the member's case manager. An IHS referral is not required for ALTCS services.

Native American ALTCS members considered to be residing off-reservation are enrolled with an ALTCS Contractor and all non-emergency medically necessary transportation is coordinated, authorized and provided through the Contractor.

Refer to Chapter 1600 of this Manual for additional information regarding case management authorization requirements.

Refer to Chapter 800 for complete information regarding prior authorization, and for information regarding IHS referral requirements.

Refer to the AHCCCS FFS Provider Manual or the IHS/Tribal Providers Billing Manual for billing information. These manuals are available on the AHCCCS Web site at www.ahcccs.state.az.us.

- **TRIAGE/SCREENING AND EVALUATION OF EMERGENCY MEDICAL CONDITIONS**

Description. Covered services for managed care and FFS members not in the FESP (refer to Chapter 1100 for all requirements regarding the FESP), when provided by acute care hospitals, IHS facilities and urgent care centers to determine whether or not an emergency exists, assess the severity of the member's medical condition and determine what services are necessary to alleviate or stabilize the emergent condition.

Amount, Duration, and Scope. Triage/screening services must be reasonable, cost effective and meet the criteria for severity of illness and intensity of service.

Refer to Chapter 800 for PA and utilization review requirements for FFS members.

Refer to Chapter 1100 for information and requirements regarding the FES Program.

- **COVERED TRANSPLANTS AND RELATED IMMUNOSUPPRESSANT MEDICATIONS**

Description. Organ transplant services are not mandatory covered services under Title XIX, and each State has the discretion to choose whether or not transplants will be available to members. The AHCCCS Administration, as the single State agency, has the authority under Federal law to determine which transplant procedures, if any, will be reimbursed as covered services.

When a State elects to cover transplant services, Federal law 42 USC §1396b(i) limits Federal financial participation to only those organ transplant procedures with written standards of coverage described in the State Plan. Additionally, Federal provisions authorize the Title XIX agency to impose limits on transplant services based on medical necessity and to place restrictions on the facilities and practitioners performing organ transplant procedures as long as they are consistent with accessibility to high quality care (Title 42 of the Code of Federal Regulations [42 CFR] 441.35).

AHCCCS covers medically necessary transplantation services and related immunosuppressant medications in accordance with Federal and State law and regulations.

The solid organ and tissue transplant services described in this policy, including the relevant standards of coverage, are referenced in the AHCCCS State Plan. The AHCCCS State Plan is the document approved by the Federal government which outlines the eligibility requirements and covered services for the AHCCCS program.

As with other AHCCCS-covered services, transplants must be medically necessary, cost effective, Federally reimbursable and State reimbursable. Arizona State regulations specifically address transplant services, as follows:

- Non-experimental transplants which are approved for Title XIX reimbursement are covered services (Arizona Revised Statute [A.R.S.] §36-2907).

- Services which are experimental, or which are provided primarily for the purpose of research are excluded from coverage (Arizona Administrative Code [A.A.C.] R9-22-201).

- Medically necessary is defined as those covered services "provided by a physician or other licensed practitioner of the healing arts within the scope of practice under State law to prevent disease, disability or other adverse health conditions, or their progression, or prolong life" (A.A.C. R9-22-101).

- Experimental services are defined as "services associated with treatment or diagnostic evaluation and that are not generally and widely accepted as standard of care in the practice of medicine in the United States unless:

  - The weight of the evidence in peer-reviewed articles in medical journals published in the United States supports the safety and effectiveness of the service, or

  - In the absence of peer-reviewed articles, for services that are rarely used, novel or relatively unknown in the general professional medical community, the weight of opinions from specialists who provide the service attests to the safety and effectiveness of the service". (A.A.C. R9-22-101)

- Standard of care is defined as "a medical procedure or process that is accepted as treatment for a specific illness, injury or medical condition through custom, peer review or consensus by the professional medical community" (A.A.C. R9-22-101).

In developing this policy, the AHCCCS Administration has consulted with transplant experts to develop criteria for transplant coverage consistent with the current body of medical literature, including United Network for Organ Sharing (UNOS) clinical standards for transplant procedures as well as peer-reviewed articles in medical journals published in the United States.

It is the AHCCCS Administration's position that the criteria delineated in this policy represent current accepted transplant medical knowledge and the current standard of care in the professional transplant community for determining when transplants are medically necessary and non-experimental. Emerging technologies and advances in medical treatments will likely alter the standards set forth in this policy. In light of the evolving body of transplant knowledge, it is expected that each AHCCCS Contractor will consult with up-to-date authoritative medical sources to determine whether a particular transplant is medically necessary and non-experimental, and provide the medical justification for the decision that is made.

The transplant policy sets forth criteria, including indications and contraindications, for determining whether transplant services are medically necessary and non-experimental. Contraindications are conditions which may significantly adversely impact the outcome of the transplant, however, they are not regarded as an absolute bar to transplantation. Contraindications must be evaluated along with all other relevant factors to determine whether the transplant service is medically necessary and non-experimental in the particular case.

Both general and organ/tissue specific contraindications are listed in this policy. General contraindications are found under the heading "General Contraindications", and organ/tissue specific contraindications are identified in Attachment A. This policy also describes some of the general medical conditions which must be considered to determine the appropriateness of the transplant. The general medical conditions that must be evaluated in establishing the medical necessity and the non-experimental nature of the transplant service are found under the heading "General Medical Conditions that Must be Considered".

Transplant services are covered only when performed in specific settings:

- Solid organ transplantation services must be provided in a CMS certified transplant center that is contracted with AHCCCS and that is also a UNOS approved transplant center, unless otherwise approved by the member's Contractor, and/or the AHCCCS Chief Medical Officer (CMO), Medical Director or designee.

- Stem cell and bone marrow transplantation services must be provided in a facility that has achieved Foundation for the Accreditation of Cellular Therapy (FACT) accreditation as a stem cell and bone marrow transplant center and is contracted with AHCCCS, unless otherwise approved by the member's Contractor, and/or the AHCCCS Chief Medical Officer (CMO), Medical Director or designee.

Transplantation related services and immunosuppressant drugs are not covered services for individuals in the FES program, pursuant to 42 USC 1396b(v)(3) and A.A.C. R9-22-206. Persons who qualify for transplant services, but who are later determined ineligible under A.R.S. 36-2907.10 due to excess income may qualify for extended eligibility (refer to Attachment B). For information about transplants and reinsurance, refer to the AHCCCS Contract.

A. The first step in the assessment for transplant coverage is the initial evaluation by the member's PCP and/or the specialist treating the condition necessitating the transplant. In determining whether the member is appropriate for referral for transplant services, the PCP/specialist must determine that all of the following conditions are satisfied:

   1. The member will be able to attain an increased quality of life and chance for long-term survival as a result of the transplant

   2. There are no significant impairments or conditions that would negatively impact the transplant surgery, supportive medical services, or inpatient and outpatient post-transplantation management of the member

   3. There are strong clinical indications that the member can survive the transplantation procedure and related medical therapy (e.g., chemotherapy, immunosuppressive therapy)

   4. There is sufficient social support to ensure the member's compliance with treatment recommendations such as, but not limited to, immunosuppressive therapy, other medication regimens and pre- and post-transplantation physician visits, and

   5. The member's condition has failed to improve with other conventional medical/surgical therapies. This information must be documented and submitted to the Contractor at the time of request for evaluation.

B. The following solid organ and tissue transplants are AHCCCS covered services when medically necessary and non-experimental. For detailed criteria regarding specific transplants, refer to Attachment A.

   1. Heart

   2. Heart/Lung

   3. Lung – single and double

   4. Liver

5. Kidney (cadaveric and live donor)

6. Simultaneous Pancreas/Kidney and Pancreas after Kidney

7. Intestinal transplantation (pediatric members only)

   a. Small Bowel

   b. Liver/Small Bowel

NOTE: Live donor transplants may be considered on a case-by-case basis for solid organs other than kidney when medically appropriate.

8. Bone Marrow or Stem Cell

   a. Allogeneic (related and unrelated)

   b. Autologous

   c. Related and unrelated cord blood stem cell (for specific diagnoses in children and adults)

9. Donor Lymphocyte Infusion (DLI)

10. Tandem bone marrow transplants or double organ transplantation consisting of multiple of the above covered organs is covered.

C. Ventricular Assist Device (VAD) is an AHCCCS covered service when used as a bridge to transplantation and other specific criteria are met (refer to Attachment A).

D. Bone grafts and corneal transplants are AHCCCS covered services.

Amount, Duration and Scope. Coverage of transplantation services includes the following components of service, as required by the specific type of transplantation:

A. For the transplant recipient and donor:

1. Pre-transplant evaluation (inpatient or outpatient), which includes, but is not limited to, the following:

   a. Physical examination

   b. Psychological and social service evaluations

   c. Laboratory studies

   d. Diagnostic imaging, and

   e. Biopsies

2. Medically necessary post-transplant care (inpatient and outpatient), which may include, but is not limited to, the following:

   a. Laboratory studies

   b. Diagnostic imaging

   c. Biopsies, and

   d. Treatment of complications

B. Additional covered services for the transplant recipient only:

1. Nutritional assessment

2. Dental evaluation and treatment for oral infection. (For adults, this service is limited to diagnosis and treatment for the elimination of oral infection, and will commence only after the member has been established as an otherwise appropriate candidate.) Other dental services, including, but not limited to, restorative and cosmetic dentistry, will not be covered.

3. Pre-transplant inpatient and outpatient donor search

4. Room and board for the transplant recipient and, if needed, one adult caregiver during the time it is necessary for the member to remain in close proximity to the transplant center

5. Hospitalization from the date of admission for the transplant to discharge

6. Transportation for the transplant recipient and, if needed, one adult caregiver to and from medical treatment during the time it is necessary for the member to remain in close proximity to the transplant center

7. All related medications, including immunosuppressants. Note: AHCCCS is the secondary payer of immunosuppressant medications if the member is also a Medicare beneficiary and is eligible to receive the immunosuppressant medications under either Medicare Part B or Part D.

8. Post-transplant discharge evaluations

C. Additional covered services for the donor:

1. Inpatient or outpatient donor organ, tissue or cell procurement, processing and storage

2. Preparation and transplantation services from date of admission through day of transplant, and

3. Post-transplant follow-up visit.

GENERAL CONTRAINDICATIONS

General contraindications to solid organ and tissue transplantation include, but are not limited to:

1. History of non-compliance or psychiatric condition(s) such that there is an inability to comply with an immunosuppression protocol

2. HIV positive status and viral load – members whose HIV status makes them ineligible for AHCCCS coverage of transplantation have the potential to enroll in one of the National Institute of Health's approved clinical trials. These transplants are subject to the policy described in the section of this policy entitled "Medically Necessary Services for Members who Receive Transplants that are Not Covered by AHCCCS".

3. Active malignancy (other than hepatocellular carcinoma for liver transplants) or prior metastatic disease. This is a contraindication to solid organ transplant, not stem cell transplant.

4. The failure of more than two organs. This does not include instances where the failure of one organ is secondary to the failure of another organ.

5. Presence of active infection other than that which has caused the underlying organ failure.

6. Active substance abuse or history of substance abuse in the last six months. (If there is an urgent need, evaluation only may be allowed on a case-by-case basis.)

GENERAL MEDICAL CONDITIONS WHICH MUST BE CONSIDERED

The general medical conditions that must be evaluated prior to transplant to determine whether a particular transplant is medically necessary and non-experimental include, but are not limited to:

1. Morbid obesity (body mass index [BMI] of > 39 kg/m^2). This consideration does not pertain to stem cell and bone marrow transplantation.

2. For members with a history of substance abuse, six months of current, ongoing attendance in an approved substance abuse program, plus a patient-signed contract, sponsor and paper documentation of attendance in the program are required prior to determination for transplant listing. For members with a remote history of substance abuse (greater than three years prior), attendance in an approved substance abuse program may be waived. All members with a history of substance abuse must have three consecutive negative random screens reported by the PCP and/or specialist prior to the referral to the transplant facility for evaluation. In addition, the member will be monitored with random and repeated alcohol and/or drug screening during the assessment process up to the time of the transplant.

3. Comorbid conditions (e.g., systemic lupus erythematosis, cystic fibrosis, sarcoidosis) are relative contraindications, based on the severity of the disease.

Out-of-Network Coverage. AHCCCS provides out-of-network coverage for solid organ or stem cell and bone marrow transplants for those members who have current medical requirements that cannot be met by an appropriate in-network transplant center. These medical requirements must be manifested as requiring either a specific level of technical expertise or program coverage that is not currently provided by AHCCCS contracted facilities. A request for out-of-network coverage will not be approved if the member has already received a medical denial from an approved transplant center. Quality, outcome data and cost containment standards will all be considered in the final determination for use of out-of-network transplant centers.

When a member completes an AHCCCS approved transplantation at an out-of-network facility, the necessary follow-up services will be covered through an AHCCCS contracted in-network facility, if one is available. These services include, but are not limited to, travel, lodging, meals, medical testing and post-operative evaluation and apply to any transplant performed under AHCCCS coverage, another third-party payer or through self-pay.

Multiple Site Listing for Solid Organ/Stem Cell and Bone Marrow Transplantation. If a member seeks to be evaluated for solid organ, stem cell or bone marrow transplantation, and is "listed" with more than the primary approved transplant center, AHCCCS will not pay for any of the other center's evaluation services or any travel, lodging or meals.

In the event that a member becomes listed by a facility other than the primary approved transplant center, AHCCCS will not provide coverage for any costs over and above the state-contracted rate for the specific transplant procedure.

In addition, facility reimbursement will be available only to FACT accredited or CMS certified and UNOS approved transplant centers unless otherwise approved by the member's Contractor, and/or the AHCCCS CMO, Medical Director or designee, and will be limited to the immediate hospitalization for the transplantation surgery and the inpatient post-operative care.

If a member chooses to make their own arrangements for travel, lodging and/or meals, then the member must notify their Contractor (or AHCCCS if they are a fee-for-service [FFS] member), of the arrangements they have made, and for securing and sending appropriate medical records to the appropriate transplant case manager. If the member is receiving services on an FFS basis through AHCCCS Administration, appropriate medical records must be sent to the transplant case manager in the AHCCCS Division of Health Care Management.

Medically Necessary Services for Members who Receive Transplants that are Not Covered by AHCCCS. If a member receives a transplant that is not covered by AHCCCS, medically necessary, non-experimental services commence following discharge from the acute care hospitalization for the transplant.

A. Services include, but are not limited to:

1. Transitional living arrangements appropriately prescribed for post-transplant patients

2. Essential laboratory and radiology procedures

3. Medically necessary post-transplant therapies

4. Immunosuppressant medications, and

5. Medically necessary transportation

B. Covered services do not include:

1. Evaluations and treatments to prepare for transplant candidacy

2. The actual transplant procedure and accompanying hospitalization, or

3. Organ or tissue procurement.

AHCCCS reimbursement of the Contractor for medically necessary services following non-covered organ transplantation is in accordance with the regular reinsurance policy. Reimbursement in accordance with catastrophic reinsurance policy is reserved for AHCCCS-covered transplantation.

Transplantation Management. The AHCCCS Administration has entered into a contract with a transplantation management entity (Consultant) to review developments, outcomes and respective changes in technology, and assist in the development and revision of this policy. The Consultant will be available, as necessary, to advise on cases that require expert opinion regarding transplantation services.

AHCCCS, in partnership with the Consultant, will provide medical expertise for specific diagnoses and medical conditions that are covered for transplantation.

Consultation may include, but is not limited to:

1. Telephone access to the Consultant Medical Director. Access will be arranged by the AHCCCS Chief Medical Officer or designee.

2. Regular updates on changes in experimental status of selected transplants and advances in technology and devices

3. Analysis of transplantation and related technology developments with enough information, including cost projections, to assist AHCCCS in revising this policy and Attachment A as necessary, and

4. Assistance in recommendation of approved/appropriate transplant facilities, as necessary, for out-of-network coverage.

References.

1. Attachment A of this Policy for criteria for specific solid organ and tissue transplants.

2. Attachment B of this Policy for extended eligibility process/procedure

3. Chapter 500 for information regarding care coordination for transplant candidates who experience an interruption of eligibility or enrollment

4. Chapter 800 for fee-for-service prior authorization requirements for providers

5. AHCCCS Division of Health Care Management, Reinsurance Claims Processing Manual, for information regarding Contractor applications for transplantation reinsurance, and

6. The AHCCCS Contracts for further information regarding transplants and reinsurance.

ATTACHMENT A

SOLID ORGAN AND TISSUE TRANSPLANTS AND RELATED DEVICES INDICATIONS AND CONTRAINDICATIONS/LIMITATIONS

ATTACHMENT A

SOLID ORGAN AND TISSUE TRANSPLANTS AND RELATED DEVICES
INDICATIONS AND CONTRAINDICATIONS

Refer to the main body of this policy (Chapter 300, Policy 310, "Covered Transplants and Related Immunosuppressant Medications") for additional information and general criteria.

Covered Transplants

1. Heart
2. Heart/Lung
3. Lung – single and double
4. Liver
5. Kidney (Cadaveric and Live Donor)
6. Simultaneous Pancreas/Kidney and Pancreas After Kidney
7. Intestinal Transplantation (pediatric members only)
    a. Small bowel
    b. Liver/small bowel
9. Stem Cell and Bone Marrow
    a. Allogeneic
    b. Autologous
    c. Related and unrelated cord blood for some diagnoses in children and adults
10. Donor Lymphocyte Infusion (DLI)
11. Tandem bone marrow transplants or double organ transplantation consisting of multiple of the above covered organs is covered.

NOTE: A live donor transplant may be considered on a case-by-case basis for solid organs other than the kidney. AHCCCS Contractors should evaluate the risk to benefit ratio in determining approval of live donor transplants.

Covered Devices

Ventricular assist devices (VADs) as bridge to transplant only.

ATTACHMENT A

SOLID ORGAN AND TISSUE TRANSPLANTS AND RELATED DEVICES
INDICATIONS AND CONTRAINDICATIONS

Heart

Prior to heart transplant, all other medical and surgical therapies which might be expected to yield both short-and long-term survival (3 to 5 years) must have been tried or considered.

Criteria for medical necessity of heart transplantation in adults and children include, but are not limited to, the following indications:

1. End-stage heart disease
2. Ischemic myocardial disease
3. Idiopathic cardiomyopathy
4. Valvular disease
5. Congenital cardiac disease
6. Myocardial disease (e.g., sarcoidosis and amyloidosis)
7. Drug-induced myocardial destruction due to prescription medication
8. Class IV cardiac disease when surgical or medical therapy is not pertinent and estimated survival is less than 6 to 12 months without a transplant

In addition to those defined in Policy 310, the following are contraindications to heart transplantation:

1. Severe pulmonary hypertension
2. Renal or hepatic dysfunction not explained by the underlying heart failure and not deemed reversible
3. Acute severe hemodynamic compromise at the time of transplantation if accompanied by compromise or failure of one or more vital end-organs

4. Symptomatic peripheral or cerebral vascular disease

5. Chronic obstructive pulmonary disease or chronic bronchitis

6. Recent and unresolved pulmonary infarction

7. Systemic hypertension, either at transplantation or prior to development of end-stage heart disease, which required multi-drug therapy for even moderate control (for patients who would be on cyclosporine protocols)

8. Cachexia, even in the absence of major end-organ failure

9. The need for or prior transplantation of another organ such as lung, liver, kidney or stem cell or bone marrow, or

10. The use of a donor heart which may have had its effectiveness compromised by such factors as the use of substantial vasopressors prior to its removal from the donor, prolonged or compromised maintenance between the time of its removal from the donor and its implantation into the patient, or preexisting disease.

Other factors which may be considered as contraindications may include, but are not limited to:

1. Insulin-dependent diabetes mellitus with end-organ disease

2. Severe peripheral or cerebrovascular disease

3. Documented peptic ulcer disease, or

4. Current or recent history of diverticulitis.

Heart and Lung

Criteria for medical necessity for heart/lung transplantation in adults and children include, but are not limited to, the following indications:

1. Irreversible primary pulmonary hypertension with congestive heart failure
2. Non-specific pulmonary fibrosis
3. Eisenmenger complex with irreversible pulmonary hypertension and heart failure
4. Cystic fibrosis with severe heart failure
5. Emphysema with severe heart failure, or
6. Chronic obstructive pulmonary disease (COPD) with severe heart failure

Lung

Criteria for medical necessity for lung transplantation in adults and children include, but are not limited to, the following indications:

1. Alpha-1 antitrypsin deficiency
2. Primary pulmonary hypertension
3. Pulmonary fibrosis, idiopathic pulmonary fibrosis
4. Bilateral bronchiectasis
5. Cystic fibrosis (both lungs to be transplanted)
6. Bronchopulmonary dysplasia
7. Eisenmenger's syndrome
8. Sarcoidosis lung involvement
9. Scleroderma
10. Lymphangiomyomatosis
11. Emphysema
12. Eosinophilia granuloma
13. Pulmonary hypertension due to cardiac disease, or
14. Idiopathic fibrosing alveolitis.

Contraindications to lung transplantation, in addition to those defined in Policy 310, include, but are not limited to:

1. Primary or metastatic malignancies of the lung
2. Acute respiratory insufficiency or failure

3. End-stage pulmonary disease with limited life expectancy

4. Abscess of lung and mediastinum

5. Current significant acute illness that is likely to contribute to a poor outcome if the patient receives a lung transplant or current use of mechanical ventilation for more than a brief period

6. Chronic pulmonary infection in candidates for single lung transplantation

7. Continued cigarette smoking or failure to have abstained for long enough to indicate low likelihood of recidivism

8. Systemic hypertension that requires more than two drugs for adequate control

9. Inadequate biventricular cardiac function, significant coronary artery disease

10. Cachexia, even in the absence of major end-organ failure

11. Previous thoracic or cardiac surgery or other basis for pleural adhesions

12. Chronic cortisone therapy or recent therapeutic use of systemic steroids

13. System-wide involvement of cystic fibrosis

Liver

Criteria for medical necessity for liver transplantation in **adults** include, but are not limited to, the following indications:

1. Fulminant hepatic failure – This is an emergent basis for transplant.
2. Primary/secondary biliary cirrhosis
3. Primary sclerosing cholangitis
4. Cryptogenic or autoimmune cirrhosis
5. Chronic active hepatitis due to Hepatitis B, C or delta hepatitis
6. Alcoholic liver disease after a period of abstinence of six months or more
7. Alpha-1 antitrypsin deficiency
8. Wilson's disease
9. Primary hemochromatosis
10. Protoporphyria
11. Familial cholestasis (Byler's disease)
12. Trauma
13. Drug- or toxin-induced liver disease
14. Extrahepatic biliary atresia, intrahepatic bile duct paucity (Alagille's syndrome)
15. Budd-Chiari syndrome, and

16. Hepatocellular carcinoma (HCC) when the following conditions are met:

    a. The patient is not a candidate for subtotal liver resection.

    b. The patient has a single tumor less than or equal to 5 cm in diameter, or has less than three tumors that all are less than or equal to 3 cm in diameter, and

    c. There is no macrovascular involvement or identifiable extrahepatic spread of tumor to surrounding lymph nodes, lungs, abdominal organs or bones

Contraindications to liver transplantation in **adults**, in addition to those defined in Policy 310, include, but are not limited to:

1. Malignancies, other than HCC with the above stated criteria

2. Acute severe hemodynamic compromise at the time of transplant if accompanied by compromise or failure of one or more vital organs

3. The need for prior transplantation of another organ such as lung, kidney, heart or blood or marrow if this represents a co-existence of significant disease, or

4. Insulin-dependent diabetes mellitus with end-organ disease

Medical necessity for liver transplantation in **children** may be based on the following indications:

1. Intractable cholestasis

2. Portal hypertension

3. Multiple episodes of ascending cholangitis

4. Failure of synthetic function

5. Failure to thrive, malnutrition

6. Intractable ascites

7. Encephalopathy, or

8. Metabolic defects for which liver transplantation will reverse life-threatening illness and prevent irreversible central nervous system (CNS) damage

Contraindications to liver transplantation in **children**, in addition to those defined in Policy 310 include, but are not limited to:

1. Malignancy extending beyond the margins of the liver, and

2. Persistent viremia.

Kidney

Criteria for medical necessity for live donor or cadeveric kidney transplantation in adults and children includes, but is not limited to, the following indications:

1. Chronic renal failure

2. Impending long-term dialysis

3. End stage renal disease which may arise from the following conditions:

    a. Glomerulonephritis

        - Proliferative
        - Membranous
        - Mesangio-capillary

    b. Chronic pyelonephritis

    c. Hereditary conditions

        - Polycystic disease
        - Medullary cystic disease
        - Nephritis (including Alport's syndrome)

    d. Hyperactive nephrosclerosis

    e. Metabolic conditions

        - Cystinosis
        - Amyloid
        - Gout

f. Congenital conditions

- Hyperplasia
- Horseshoe kidney

g. Toxic conditions

- Analgesic nephropathy
- Heavy metal poisoning

h. Irreversible acute renal failure

- Cortical necrosis
- Acute tubular necrosis

For **pediatric** kidney transplants, additional criteria for transplantation include, but are not limited to:

1. Wilm's tumor (non-metastatic)
2. Oxalosis (may also require a liver-kidney transplant and will be considered on a case-by-case basis)

Contraindications to kidney transplantation (**pediatric and adult**), in addition to those defined in Policy 310, include, but are not limited to:

1. Potential complications from immunosuppressive regimens are unacceptable to the patient (the benefits of remaining on dialysis outweigh the risks of transplantation)
2. Hepatitis C infection
3. Problems or abnormalities with the lower urinary tract

Living Kidney Donor Exclusion Criteria

A living kidney donor must not be or have the following:

1. Age less than 18 or over 65 years

2. Hypertension (>140/90 or requires medication)
3. Diabetes or abnormal glucose intolerance test
4. Proteinuria >250 mg/24 hours
5. Recent or recurrent kidney stones
6. Abnormal glomerular filtration rate, creatinine clearance <80 mL/min
7. Microscopic hematuria
8. Urologic abnormalities in donor kidney
9. Significant co-morbid medical conditions, (e.g., malignancy, COPD, etc.)
10. Obesity (30% over ideal body weight) See Appendix I for BMI charts.
11. History of thrombosis or thromboembolism
12. Psychiatric contraindications including active substance abuse.

Simultaneous Pancreas/Kidney and Pancreas After Kidney

Covered services are limited to total pancreas only; partial pancreas and islet cell transplantations are not covered as medical efficacy of such transplants has not been demonstrated. Islet cell transplantation is being provided under clinical research through the National Institutes of Health.

Criteria for medical necessity for simultaneous pancreas/kidney transplantation in adults and children include, but are not limited to the following indications:

1. Insulin-dependent diabetes mellitus with impending renal failure

2. The patient is an acceptable candidate for pancreas transplantation and has no living kidney donor available

Criteria for medical necessity of pancreas after kidney transplantation in adults and children include, but are not limited to the following indication:

1. The patient has already received a kidney and has achieved adequate renal function

Contraindications to simultaneous pancreas/kidney transplantation and pancreas after kidney transplantation, in addition to those defined in Policy 310, include, but are not limited to:

1. Uncorrectable cardiovascular disease

2. Ejection fraction <30%

3. Peripheral vascular disease that is not correctable

4. Active substance abuse, or

5. End-organ disease, in other than pancreas or kidney, secondary to insulin-dependent diabetes mellitus.

Intestinal (**pediatric** members only)

Criteria for medical necessity for intestinal transplantation in children, who are eligible through the month of their 21st birthday, include, but are not limited to, the following indications:

1. Small bowel syndrome resulting from inadequate intestinal propulsion due to neuromuscular impairment

2. Small bowel syndrome resulting from post-surgical conditions due to resections for:

    a. Intestinal cysts

    b. Mesenteric cysts

    c. Small bowel or other tumors involving small bowel

    d. Crohn's disease

    e. Mesenteric thrombosis, or

    f. Volvulus

3. Short-gut syndromes in which there is liver function impairment (usually secondary to total parenteral nutrition [TPN])

Criteria for intestinal transplantation alone, small bowel (SB) and combined small bowel/liver transplantation (SB/LT) include, but are not limited to the following conditions:

1. Impending or overt liver failure due to TPN-induced liver injury, with clinical manifestations including elevated serum bilirubin and/or liver enzymes, splenomegaly, thrombocytopenia, gastroesophageal varices, coagulapathy, stomal bleeding or hepatic fibrosis/cirrhosis

2. Thrombosis of two or more major central venous channels (jugular, subclavian or femoral veins)

3. Two or more episodes per year of systemic sepsis secondary to line infection, which require hospitalization, indicating failure of TPN therapy, or

4. Frequent episodes of severe dehydration despite intravenous fluid supplement in addition to TPN.

Bone Marrow and Stem Cell

Criteria for medical necessity for allogeneic and autologous bone marrow and stem cell transplantation in adults and children include, but are not limited to the following indications:

A. Allogeneic transplantation

(Myeloablative only unless otherwise indicated)

1. Acute lymphocytic leukemia (ALL)
2. Acute myeloid leukemia (AML)
3. Aplastic anemia
4. Chronic myelogenous leukemia (CML)
5. Fanconi anemia (FA)
6. Hodgkin's disease (recurrence only – not as an initial treatment)
7. Metabolic storage diseases on a case-by-case basis (e.g., lysosomal storage diseases, metachromatic leukodystrophy, arylsulfatase A deficiency). Genetic diseases have not been determined to be cured from bone marrow or stem cell transplant and are under research at this time.
8. Recurrent non-Hodgkin's lymphoma
9. Osteopetrosis
10. Primary lethal immune deficiencies and hemophatocytic lymphohistiocytosis
    a. Wiskott-Aldrich Syndrome
    b. Severe combined immune deficiencies
11. Sickle cell disease, where benefit to risk has been established for the case
12. Severe congenital anemia
13. Thalassemia

14. Myelodysplastic syndrome

15. Juvenile monomyelocytic leukemia (JMML)

16. Primary amyloid light chain amyloidosis

B. <u>Autologous transplantation</u>
(following high-dose chemotherapy [HDC] and/or radiotherapy)

1. Acute lymphocytic leukemia (ALL) (in patients without a suitable donor for allogeneic transplantation) (for **adults** only)

2. Acute myeloid leukemia (AML) (in patients without a suitable donor for allogeneic transplantation) (for **adults** only)

3. Germ cell tumors

4. Hodgkin's disease with responsive disease

5. Multiple myeloma (MM)

    a. Physiologic age of 60 or under

    b. A minimum of three months must elapse between transplants

    c. There must be a re-staging and assessment of response before the second transplant

    d. Only patients with less than a partial or very good remission, as measured from the start of initial therapy, are good candidates for the second transplant, and

    e. Melphalan-only regimen for both transplants, at a dosage range of 140-200 mg/kg

6. Neuroblastoma

7. Non-Hodgkin's lymphoma (NHL) with responsive disease, or

8. Wilm's tumor

C. Related and unrelated cord blood

Medical necessity for cord blood transplantation (CBT) in children and adults will be determined on a case-by-case basis. For any pediatric CBT, a single cord blood unit will be considered standard treatment.

NOTE: A single unit pediatric CBT is allowed for diseases listed under allogeneic, single unit only.

D. Donor Lymphocyte Infusion (DLI)

Donor lymphocyte infusion is a specific infusion of allogeneic donor-derived lymphocytes (T-cells) either harvested from blood, marrow or peripheral T-cells harvested with the use of an apheresis machine. Medical necessity for donor lymphocyte infusion may be considered in pediatric and younger adult members with chronic myelogeneous leukemia who experience a relapse after an allogeneic stem cell or bone marrow transplant or who do not respond to withdrawal of immunosuppressive medication.

Ventricular Assist Device (are covered under the transplant reinsurance policy as bridge to transplant only)

AHCCCS covers Ventricular Assist Devices (VADs) as a bridge to heart transplant for eligible members when medically necessary, non-experimental and when the device is used in accordance with the Food and Drug Administration (FDA) approved labeling instructions.

AHCCCS-contracted transplant center surgeons use their skill and judgment to select the appropriate assist device, based on:

- Degree and presentation of cardiac insufficiency
- Size of recipient, and
- Device capability.

Medical necessity for VADs as a bridge to transplant is based on the following criteria:

A. The potential **adult** recipient must meet **all** of the following:

1. Has been accepted and listed for cardiac transplantation
2. Is experiencing end stage heart failure with progressive failure to respond to medical management and meets the definition of cardiogenic shock, manifested by any two of the following:
    a. Cardiac index < 2.0 liters/m^2/min
    b. Need for at least two inotropes and unable to wean
    c. Systemic vascular resistance >2100 dyn/sec/cm^2
    d. Atrial pressure > 20 mm Hg
    e. Right atrial pressure > 16 mm Hg, pulmonary capillary wedge pressure (PWCP) >16 mm Hg
    f. Systemic hypotension (systolic pressure < 80 mm Hg)

g. Urine output < 20 mL/hr, or

h. Metabolic acidosis

B. The potential **pediatric** recipient must meet **all** the following:

1. Has been accepted and listed for cardiac transplantation

2. Must meet the age restrictions established by the FDA for the particular device used

3. Has a body surface area (BSA) $\geq 0.7m^2$ and $< 1.5\ m^2$

4. Is in New York Heart Association class IV end-stage heart failure, and

5. Is refractory to medical therapy.

C. Contraindications to successful VAD transplantation and subsequent recovery include, but are not limited to:

1. Severe lung disease, except as appropriate for heart-lung transplantation (refer to the section pertaining to lung and heart-lung transplantation in this appendix)

2. Malignant disease

3. Stroke or refractory hypertension

4. Chronic pulmonary embolism or recent pulmonary infarction, except as appropriate for heart-lung transplantation (refer to the section pertaining to lung and heart-lung transplantation in this appendix)

5. Active infection

6. Irreversible disease of a major organ system, or

7. Critical psychosocial conditions, behaviors or problems in adherence to a disciplined medical regimen which preclude a positive transplant outcome.

ATTACHMENT B

EXTENDED ELIGIBILITY PROCESS/PROCEDURE FOR COVERED SOLID ORGAN AND TISSUE TRANSPLANTS

ATTACHMENT B

EXTENDED ELIGIBILITY PROCESS/PROCEDURE FOR COVERED SOLID ORGAN AND TISSUE TRANSPLANTS

Individuals found eligible for a transplant who subsequently lose eligibility for AHCCCS due to excess income may become eligible for one of two extended eligibility options. This extended eligibility process is authorized only for those individuals who meet **all** of the following conditions:

- Have been determined ineligible due to excess income under one of the covered Title XIX acute care groups including the medical expense deduction category

- Have been approved for a medically necessary and appropriate transplant and have been placed on a donor waiting list before eligibility expired, and

- Have entered into a contractual arrangement with the transplant facility to pay the amount of income, which is in excess of the eligibility income standards (referred to as transplant share of cost).

CASE COORDINATION

Since eligible individuals receive as little as 10 days notification by mail that their eligibility will end, it is essential that all transplant candidates receive early instructions about what to do and where to go to have eligibility redetermined.

Once the AHCCCS Division of Health Care Management (DHCM) Transplant Coordinator has been notified by the Contractor and the transplant facility that an individual is approved as a candidate for a transplant, a transplant status letter is sent to that individual. The letter informs the individual to immediately contact the Contractor Transplant Coordinator and the Transplant Facility Social Worker should he/she receive notification of pending termination from AHCCCS. In addition, the AHCCCS DHCM Transplant Coordinator will work closely with the Contractor's Transplant Coordinator to monitor the member's eligibility status for any changes.

The Contractor's Transplant Financial Coordinator is responsible for discussing the available extended eligibility options for coverage.

ATTACHMENT B

EXTENDED ELIGIBILITY PROCESS/PROCEDURE FOR COVERED SOLID ORGAN AND TISSUE TRANSPLANTS

The following two options for extended eligibility are available for these qualified individuals:

OPTION 1

This option is intended to extend all AHCCCS covered services.

- Extended eligibility is for one 12-month continuous period of time and is funded by Tobacco Tax funds.

- Tobacco Tax funds will be used to pay the state share of capitation, reinsurance and catastrophic reinsurance which is equal to the contracted rate of the transplant, including up to 60 days post-transplant care (10 days for kidneys), less the transplant share of cost.

- The transplant share of cost will be determined based on the total unmet spend down requirement for the household divided by the number of individuals in the household and will be calculated by the AHCCCS Central Eligibility Unit (CEU).

- The contracting transplant facility must submit a copy of the individual's contractual agreement with the facility to the AHCCCS Division of Member Services (DMS).

- The amount of transplant share of cost shall not change once the extended period of eligibility begins.

- If an individual elects Option 1, he or she cannot switch to Option 2.

At the end of the 12-month period, the individual must qualify for AHCCCS based on regular eligibility requirements, or they will lose AHCCCS eligibility. Or, if during the 12-month period, the individual is determined to be no longer medically eligible for a transplant, their coverage will terminate at the end of that month.

NOTE: If during the 12-month period the individual becomes eligible for Title XIX coverage, the 12-month period continues. However, if the transplant takes place while the person is Title XIX eligible, there is no share of cost.

ATTACHMENT B

EXTENDED ELIGIBILITY PROCESS/PROCEDURE FOR COVERED SOLID ORGAN AND TISSUE TRANSPLANTS

OPTION 2

In this option, the individual who loses Title XIX eligibility is allowed to retain their status on the transplant donor waiting list until such time as the transplant is scheduled or performed. The individual is not eligible for any health care services from AHCCCS while waiting for the transplant unless at any time the individual qualifies for AHCCCS based on regular eligibility requirements. If the transplant facility enters into the contractual agreement with the person, the facility must allow that person to retain their transplant candidacy status, as long as the person is medically eligible. The contracting transplant facility must submit a copy of the individual's contractual agreement with the facility to DMS.

- Once the transplant is scheduled or performed, the individual may reapply for Title XIX eligibility. At re-application, if determined Title XIX ineligible solely due to excess income, the transplant share of cost will be recalculated based on current income and family size. The transplant candidate who signs a contract with the transplant facility to pay the transplant share of cost will be enrolled with an AHCCCS Contractor to receive all covered applicable transplant services.

- Tobacco Tax funds will be used to pay the state share of capitation, reinsurance and catastrophic reinsurance which is equal to the contracted rate of the transplant, including up to 60 days post transplant care (10 days for kidneys), less the transplant share of cost (spend down) amount.

While the person is enrolled with a Contractor, Tobacco Tax funds will be used to pay the medical cost associated with the transplant, less the transplant share of cost, if the transplant is performed within 30 days prior to the date of eligibility determination by the eligibility office.

At any time, the individual may qualify for AHCCCS based on regular eligibility requirements.

Transplant Candidate Responsibility

Once the transplant candidate receives notification of the need for eligibility re-determination, they must contact their Contractor Transplant Coordinator to discuss the available options and contact the CEU to submit all other necessary documents to re-determine eligibility.

If an individual is too ill to complete the above process on their own, it is the responsibility of the Contractor's Transplant Coordinator and Medical Director to coordinate with DHCM, DMS and the individual to ensure that the steps outlined to initiate the re-determination process are completed on behalf of the individual.

ATTACHMENT B

EXTENDED ELIGIBILITY PROCESS/PROCEDURE FOR COVERED SOLID ORGAN AND TISSUE TRANSPLANTS

DES Responsibility

On a priority basis, DES, in coordination with the DMS representative, will determine if the person remains eligible for any Title XIX category; if not, then DES will transfer the case to the CEU.

AHCCCS CEU Responsibility

- Verify the individual's current transplant status with DHCM
- Calculate a transplant share of cost
- Inform the individual of the need to contact the transplant facility so they may discuss the two options and the contract for the transplant share of cost
- Fax the amount of the transplant share of cost to the financial coordinator at the transplant facility
- Process the extended eligibility application on a priority basis once a copy of the signed contract has been received from the transplant facility, and
- Notify the AHCCCS Member File Integrity Section when Option 1 has been selected to ensure eligibility status is updated on the AHCCCS member eligibility file.

If Option 2 is chosen, CEU will be responsible for recalculating the transplant share of cost at the time the transplant organ becomes available.

Transplant Facility Responsibility

The transplant facility staff must discuss the two options with the transplant candidate, verify the option chosen and determine whether a transplant share of cost contract will be signed.

A copy of the signed contract indicating the option chosen must be faxed by the transplant facility to the CEU and the responsible Contractor.

When a stem cell or bone marrow transplant is performed or an appropriate solid organ is available for transplant, the transplant facility will notify the AHCCCS DHCM Transplant Coordinator, and, if the candidate is enrolled, the Contractor.

ATTACHMENT B

EXTENDED ELIGIBILITY PROCESS/PROCEDURE FOR COVERED SOLID ORGAN AND TISSUE TRANSPLANTS

Contractor Responsibility

If the individual has chosen Option 1, enrollment with their current Contractor will continue for 12 months only.

If the individual has chosen Option 2, the individual is on a waiting list with the Transplant Facility, but is not on AHCCCS. At any time the individual may re-qualify for AHCCCS and at that time choose a Contractor or be auto-assigned to a new Contractor. The new Contractor will take responsibility for continuity of care.

Once the Contractor's Transplant Coordinator receives copies of the signed contract and the option chosen from the transplant facility, copies of the documents must be faxed to the AHCCCS DHCM Transplant Coordinator.

AHCCCS DHCM Responsibility

Once notified by the Contractor's Transplant Coordinator of the option chosen by the individual, the AHCCCS DHCM Transplant Coordinator will notify DMS so that eligibility can be updated.

Once notified by the transplant facility of the transplant or the availability of an organ, the AHCCCS DHCM Transplant Coordinator will begin tracking all completed components of the transplant process for review and verification of dates of services for claims.

Catastrophic Reinsurance

Claims received from the transplant facility or Contractor and reviewed by the AHCCCS DHCM Transplant Coordinator will be sent to DHCM/Catastrophic Reinsurance for adjudication or denial. An appropriate transplant case type indicator (i.e., MHL) will be established at this time for claims payment purposes.

- Exception indicators are in the system to facilitate the identification of recipients to be paid from Tobacco Tax funds.

- The amount of transplant share of cost that the individual has agreed to pay the transplant facility will be deducted by the AHCCCS system before payment is made to the transplant facility for transplant services. The AHCCCS system will not be responsible for paying any transplant share of cost if the individual fails to pay the transplant facility.

EXHIBIT 310-1

ARIZONA ADMINISTRATIVE CODE
AHCCCS RULE
EMERGENCY MEDICAL AND BEHAVIORAL HEALTH SERVICES
FOR NON-FES MEMBERS

EXHIBIT 310-1

ARIZONA ADMINISTRATIVE CODE
TITLE 9. HEALTH SERVICES
CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) ADMINISTRATION

ARTICLE 2. SCOPE OF SERVICES

R9-22-210. Emergency Medical Services for Non-Federal Emergency Services (FES) Members
R9-22-210.01. Emergency Behavioral Health Services for Non-FES Members

R9-22-210. Emergency Medical Services for Non-FES Members

A. General provisions.

1. Applicability. This Section applies to emergency medical services for non-FES members. Provisions regarding emergency behavioral health services for non-FES members are in R9-22-210.01. Provisions regarding emergency medical and behavioral health services for FES members are in R9-22-217.
2. Definitions.
   a. For the purposes of this Section, contractor has the same meaning as in A.R.S. § 36-2901. Contractor does not include ADHS/DBHS, or a subcontractor of ADHS/DBHS, or Children's Rehabilitative Services.
   b. For the purposes of this Section and R9-22-210.01, fiscal agent means a person who bills and accepts payment for a hospital or emergency room provider.
3. Verification. A provider of emergency medical services shall verify a person's eligibility status with AHCCCS, and if eligible, determine whether the person is enrolled with AHCCCS as non-FES FFS or is enrolled with a contractor.
4. Prior authorization.
   a. Emergency medical services. Prior authorization is not required for emergency medical services for non-FES members.
   b. Non-emergency medical services. If a non-FES member's medical condition does not require emergency medical services, the provider shall obtain prior authorization as required by the terms of the provider agreement under R9-22-714(A) or the provider's subcontract with the contractor, whichever is applicable.
5. Prohibition against denial of payment. The Administration and a contractor shall not limit or deny payment for emergency medical services for the following reasons:
   a. On the basis of lists of diagnoses or symptoms,
   b. Prior authorization was not obtained, or
   c. The provider does not have a subcontract.
6. Grounds for denial. The Administration and a contractor may deny payment for emergency medical services for reasons including but not limited to:
   a. The claim was not a clean claim;
   b. The claim was not submitted timely; and
   c. The provider failed to provide timely notification under subsection (B)(4) to the contractor or the Administration, as appropriate, and the contractor does not have actual notice from any other source that the member has presented for services.

B. Additional requirements for emergency medical services for non-FES members enrolled with a contractor.

1. Responsible entity. A contractor is responsible for the provision of all emergency medical services to non-FES members enrolled with the contractor.

2. Prohibition against denial of payment. A contractor shall not limit or deny payment for emergency medical services when an employee of the contractor instructs the member to obtain emergency medical services.
3. Notification. A contractor shall not deny payment to a hospital, emergency room provider, or fiscal agent for an emergency medical service rendered to a non-FES member based on the failure of the hospital, emergency room provider, or fiscal agent to notify the member's contractor within 10 days from the day that the member presented for the emergency medical service.
4. Contractor notification. A hospital, emergency room provider, or fiscal agent shall notify the contractor no later than the11th day after presentation of the non-FES member for emergency inpatient medical services. A contractor may deny payment for a hospital's, emergency room provider's, or fiscal agent's failure to provide timely notice.

C. Post-stabilization services for non-FES members enrolled with a contractor.

1. After the emergency medical condition of a member enrolled with a contractor is stabilized, a provider shall request prior authorization from the contractor for post-stabilization services.
2. The contractor is financially responsible for medical post-stabilization services obtained within or outside the network that have been prior authorized by the contractor;
3. The contractor is financially responsible for medical post-stabilization services obtained within or outside the network that are not prior authorized by the contractor, but are administered to maintain the member's stabilized condition within one hour of a request to the contractor for prior authorization of further post-stabilization services;
4. The contractor is financially responsible for medical post-stabilization services obtained within or outside the network that are not prior authorized by the contractor, but are administered to maintain, improve, or resolve the member's stabilized condition if:
   a. The contractor does not respond to a request for prior authorization within one hour;
   b. The contractor authorized to give the prior authorization cannot be contacted; or
   c. The contractor representative and the treating physician cannot reach an agreement concerning the member's care and the contractor physician is not available for consultation. In this situation, the contractor shall give the treating physician the opportunity to consult with a contractor physician. The treating physician may continue with care of the member until the contractor physician is reached or:
      i. A contractor physician with privileges at the treating hospital assumes responsibility for the member's care;
      ii. A contractor physician assumes responsibility for the member's care through transfer;
      iii. The contractor's representative and the treating physician reach agreement concerning the member's care; or
      iv. The member is discharged.
5. Transfer or discharge. The attending physician or practitioner actually treating the member for the emergency medical condition shall determine when the member is sufficiently stabilized for transfer or discharge and that decision shall be binding on the contractor.

D. Additional requirements for FFS members.

1. Responsible entity. The Administration is responsible for the provision of all emergency medical services to non-FES FFS members.
2. Grounds for denial. The Administration may deny payment for emergency medical services if a provider fails to provide timely notice to the Administration.
3. Notification. A provider shall notify the Administration no later than 72 hours after a FFS member receiving emergency medical services presents to a hospital for inpatient services. The Administration may deny payment for failure to provide timely notice.

R9-22-210.01. Emergency Behavioral Health Services for Non-FES Members

A. General provisions.

1. Applicability. This Section applies to emergency behavioral health services for non-FES members. Provisions regarding emergency medical services for non-FES members are in R9-22-210. Provisions regarding emergency medical and behavioral health services for FES members are in R9-22-217.
2. Definition. For the purposes of this Section, contractor has the same meaning as in A.R.S. § 36-2901. Contractor does not include ADHS/DBHS, a subcontractor of ADHS/DBHS, or Children's Rehabilitative Services.
3. Responsible entity for inpatient emergency behavioral health services.
   a. Members enrolled with a contractor.
      i. ADHS/DBHS. ADHS/DBHS or a subcontractor of ADHS/DBHS is responsible for providing all inpatient emergency behavioral health services to non-FES members with psychiatric or substance abuse diagnoses who are enrolled with the contractor, from one of the following time periods, whichever comes first:
         (1) The date on which the member becomes a behavioral health recipient; or
         (2) The seventy-third hour after admission for inpatient emergency behavioral health services.
      ii. Contractors. Contractors are responsible for providing inpatient emergency behavioral health services to non-FES members with psychiatric or substance abuse diagnoses who are enrolled with a contractor and are not behavioral health recipients, for the first seventy-two hours after admission.
   b. FFS members. ADHS/DBHS or a subcontractor of ADHS/DBHS is responsible for providing all inpatient emergency behavioral health services for non-FES FFS members with psychiatric or substance abuse diagnoses.
4. Responsible entity for non-inpatient emergency behavioral health services for non-FES members. ADHS/DBHS or a subcontractor of ADHS/DBHS is responsible for providing all non-inpatient emergency behavioral health services for non-FES members.
5. Verification. A provider of emergency behavioral health services shall verify a person's eligibility status with AHCCCS, and if eligible, determine whether the person is a member enrolled with AHCCCS as non-FES FFS or is enrolled with a contractor, and determine whether the member is a behavioral health recipient as defined in R9-22-102.
6. Prior authorization.
   a. Emergency behavioral health services. Emergency behavioral health services do not require prior authorization.
   b. Non-emergency behavioral health services. When a non-FES member's behavioral health condition is determined by the provider not to require emergency behavioral health services, the provider shall follow the prior authorization requirements of a contractor and ADHS/DBHS or a subcontractor of ADHS/DBHS.
7. Prohibition against denial of payment. A contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS shall not limit or deny payment to an emergency behavioral health provider for emergency behavioral health services to a non-FES member for the following reasons:
   a. On the basis of lists of diagnoses or symptoms;
   b. Prior authorization was not obtained;
   c. The provider does not have a contract;
   d. An employee of the contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS instructs the member to obtain emergency behavioral health services; or
   e. The failure of a hospital, emergency room provider, or fiscal agent to notify the member's contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS within 10 days from the day the member presented for the emergency service.
8. Grounds for denial. A contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS may deny payment for emergency behavioral health services for reasons including but not limited to the following:

a. The claim was not a clean claim,
b. The claim was not submitted timely, or
c. The provider failed to provide timely notification to the contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS.

9. Notification. A hospital, emergency room provider, or fiscal agent shall notify a contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, whichever is appropriate, no later than the 11th day from presentation of the non-FES member for emergency inpatient behavioral health services.
10. Behavioral health evaluation. An emergency behavioral health evaluation is covered as an emergency behavioral health service for a non-FES member under this Section if:
    a. Required to evaluate or stabilize an acute episode of mental disorder or substance abuse; and
    b. Provided by a qualified provider who is:
        i. A behavioral health medical practitioner as defined in R9-22-112, including a licensed psychologist, a licensed clinical social worker, a licensed professional counselor, a licensed marriage and family therapist; or
        ii. An ADHS/DBHS-contracted provider.
11. Transfer or discharge. The attending physician or the provider actually treating the non-FES member for the emergency behavioral health condition shall determine when the member is sufficiently stabilized for transfer or discharge and that decision shall be binding on the contractor and ADHS/DBHS or a subcontractor of ADHS/DBHS.

B. Post-stabilization requirements for non-FES members.

1. A contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, as appropriate, is financially responsible for behavioral health post-stabilization services obtained within or outside the network that have been prior authorized by the contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS.
2. The contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, as appropriate, is financially responsible for behavioral health post-stabilization services obtained within or outside the network that are not prior authorized by the contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, but are administered to maintain the member's stabilized condition within one hour of a request to the contractor, ADHS/DBHS, or a subcontractor for prior authorization of further post-stabilization services;
3. The contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, as appropriate, is financially responsible for behavioral health post-stabilization services obtained within or outside the network that are not prior authorized by the contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, but are administered to maintain, improve, or resolve the member's stabilized condition if:
    a. The contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, does not respond to a request for prior authorization within one hour;
    b. The contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS authorized to give the prior authorization cannot be contacted; or
    c. The representative of the contractor, ADHS/DBHS, or the subcontractor and the treating physician cannot reach an agreement concerning the member's care and the contractor's, ADHS/DBHS' or the subcontractor's physician, is not available for consultation. The treating physician may continue with care of the member until ADHS/DBHS', the contractor's, or the subcontractor's physician is reached, or:
        i. A contractor physician with privileges at the treating hospital assumes responsibility for the member's care;
        ii. ADHS/DBHS', a contractor's, or a subcontractor's physician assumes responsibility for the member's care through transfer;
        iii. A representative of the contractor, ADHS/DBHS, or the subcontractor and the treating physician reach agreement concerning the member's care; or
        iv. The member is discharged.

320 SERVICES WITH SPECIAL CIRCUMSTANCES

- **AFFILIATED PRACTICE DENTAL HYGIENIST POLICY**

Description. AHCCCS covers oral health care services as described in Chapter 400, Policy 430, EPSDT services. As allowed by State law, A.R.S. §32-1281 and §32-1289, and described in this policy, dental hygienists with an affiliated practice agreement, may provide dental hygiene services to AHCCCS members eighteen years of age and younger.

Amount, Duration and Scope. AHCCCS covers dental hygiene services provided by Arizona licensed dental hygienists subject to the terms of the written affiliated practice agreement entered into between a dentist and a dental hygienist.

Each affiliated dental hygienist, when practicing under an affiliated practice relationship may perform only those duties specified within the terms of the affiliated practice relationship and they must maintain an appropriate level of contact, communication and consultation with the affiliated practice dentist.

In addition to the requirements specified in ARS §32-1281 and §32-1289, AHCCCS requires the following:

1. Both the dental hygienist and the dentist in the affiliated practice relationship must be registered AHCCCS providers.

2. The affiliated practice dental hygienist must maintain individual patient records of AHCCCS members in accordance with the Arizona State Dental Practice Act. At a minimum this must include member identification, parent/guardian identification, signed authorization (parental consent) for services, patient medical history and documentation of services rendered.

3. The affiliated practice dental hygienist must register with AHCCCS and bill for services under his or her individual AHCCCS provider identification number / NPI number.

4. The affiliated practice dental hygienist will only be reimbursed for providing services in accordance with State regulations, AHCCCS policy and provider agreement, and their affiliated practice agreement.

AHCCCS MEMBER PARTICIPATION IN EXPERIMENTAL TREATMENT

Description. AHCCCS members who are enrolled with a Contractor, or are receiving services on a fee-for-service (FFS) basis, may participate in experimental treatment but no expenses associated with the experimental treatment are covered by AHCCCS.

Amount, Duration and Scope. If the experimental treatment provided to an AHCCCS member requires laboratory or imaging services, inpatient or other medical services, AHCCCS will not cover the added services. Coverage of care associated with complications resulting from the experimental treatment will be considered on an individual basis, but treatment of direct toxic effects are not covered. Participation in experimental treatment will not result in the loss of the member's other benefits.

The member's primary care provider must not have any financial interest in the experimental treatment and cannot accept a finder's fee for referral of a member to participate in the experiment.

Any individual expected to assess the appropriateness of services for the member cannot have a financial interest in conducting the experimental treatment, or its outcome.

Participation in a Food and Drug Administration Phase I or Phase II clinical trial must be approved by the member's Contractor, or by the AHCCCS Medical Director. If a Contractor approves participation of one or more members in an experimental trial, it must provide notice to AHCCCS/Division of Health Care Management (DHCM) and the AHCCCS Medical Director which includes assurance that the member's rights are protected and that no costs will be covered by AHCCCS. FFS member participation will be evaluated for approval by the AHCCCS Medical Director. The basis for approval will include:

1. Verification that full financial liability for the experimental treatment is taken by the researcher or the sponsor, and documentation indicates that the costs associated with the experimental treatment of direct complications or other toxic effects will not be charged to, or paid by, AHCCCS

2. The experimental treatment regimen is well designed and adequate protection of the member's welfare is assured. The trial provides adequate participant information and assures participant consent, and

3. AHCCCS Contractor employees or network providers cannot receive fees, finder's fees or other payment for referring members or providing services as a part of the experimental treatment.

- **BREAST AND CERVICAL CANCER TREATMENT PROGRAM**

Description. Effective January 1, 2002**,** the Breast and Cervical Cancer Treatment Program (BCCTP) was added as a new eligibility category under AHCCCS. The Native American Breast and Cervical Cancer Treatment technical amendment that was signed into law on January 15, 2002, made it possible for Native American women to qualify for the BCCTP coverage group even if they are eligible for health services from the Indian Health Service (IHS) or a 638 Tribal Facility.

Requirements for the program specify that a woman must be screened and diagnosed as needing treatment for breast and/or cervical cancer by one of the Arizona programs of the national Breast and Cervical Cancer Early Detection Program funded by the Centers for Disease Control (CDC). These programs are

1. The Well Woman Healthcheck Program (WWHP), administered by the Arizona Department of Health Services (ADHS)
2. The Hopi Women's Health Program, and
3. The Navajo Nation Breast and Cervical Cancer Prevention Program.

Amount, Duration and Scope. A woman who is eligible for AHCCCS under the BCCTP receives the full range of AHCCCS covered services pursuant to Arizona Administrative Code Title 9, Chapter 22, Article 20. A woman who is eligible under this program will be enrolled with a Contractor of her choice. If she does not choose one, she will be automatically assigned to one.

Treatment Services and Eligibility.

Breast Cancer - Eligibility for the breast cancer program shall conclude 12 months after the last provider visit for specific treatment of the cancer, or at the end of hormonal therapy for breast cancer, whichever is later.

Treatment includes any of the following:

1. Surgical removal of the breast cancer

2. Chemotherapy

3. Radiation therapy, or

4. A treatment that, as determined by the AHCCCS Medical Director or designee, is considered the standard of care as supported by a peer-reviewed study published in a medical journal.

Pre-cancerous cervical lesion(s) - Eligibility for the program for a pre-cancerous cervical lesion, including moderate or severe cervical dysplasia or carcinoma in situ, shall conclude four months after the last provider visit for specific treatment for the pre-cancerous lesion(s).

Treatment includes any of the following:

1. Conization

2. Loop Electrosurgical Excision Procedure

3. Cryotherapy, or

4. A treatment that, as determined by the AHCCCS Medical Director or designee, is considered the standard of care as supported by a peer-reviewed study published in a medical journal.

Cervical Cancer - Treatment for cervical cancer shall conclude 12 months after the last provider visit for specific treatment of the cancer.

Treatment includes any of the following:

1. Surgery

2. Chemotherapy

3. Radiation therapy, or

4. A treatment that, as determined by the AHCCCS Medical Director or designee, is considered the standard of care as supported by a peer-reviewed study published in a medical journal.

Metastasized Cancer - A woman's eligibility and treatment under this program will continue if a metastasized cancer is found in another part of the woman's body and the metastasized cancer is a known or presumed complication of the breast or cervical cancer.

Re-occurrence of the Cancer - A woman will have eligibility re-established, after eligibility under this program ends, if:

The woman is screened under the WWHP program or one of the Native American programs, and

1. Additional breast or cervical cancer is found, or

2. There is re-occurrence of pre-cancerous lesion(s).

Exclusions.

A male is precluded from receiving screening and diagnostic services under the National Breast and Cervical Cancer Early Detection Program and thus is ineligible under this program.

Responsibilities.

The National Breast and Cervical Cancer Early Detection Program and staff shall:

1. Direct the woman to apply to AHCCCS for treatment if the woman's screening shows a diagnosis of breast cancer, cervical cancer or pre-cancerous cervical lesion(s). However, AHCCCS eligibility cannot be determined until a positive diagnosis is confirmed.

2. Assist the woman with a Title XIX application

   A woman may apply for eligibility by completing an application for AHCCCS health insurance provided by National Breast and Cervical Cancer Early Detection Program staff. The National Breast and Cervical Cancer Early Detection Program mails the application directly to AHCCCS after receiving a positive diagnosis. A complete application contains all the information requested, including documentation verifying alien status if born outside the United States.

3. Provide AHCCCS with the diagnosis and date of diagnosis.

Responsibilities for Reporting

Background: This program is unique, in that continued eligibility is primarily determined by active treatment, and in that this program involves not only AHCCCS, but also ADHS and the CDC. The requirements for this program have created the need for special reporting by Contractors or the Native American programs as follows:

1. AHCCCS Division of Member Services (DMS) must be notified when active treatment has ended.

2. ADHS must be notified of:

   a. Date the treatment began

   b. Tumor size

   c. Tumor Stage, and

   d. Date treatment ended.

The Process for Reporting Clinical Information and Status of Treatment

1. AHCCCS Division of Member Services (DMS) will send forms to the appropriate Contractor that identify which women in the program require updated treatment information. The Contractor will complete the form and send it back to DMS.

2. For fee-for-service members, including native American program members, DMS will send forms to AHCCCS Division of Fee-for-Service Management/Prior Authorization Unit (DFSM/PA). DFSM/PA will complete the form and route it to DMS.

3. DMS will acquire the information they need from the forms and then send the forms on to ADHS.

COCHLEAR IMPLANTATION

Description. AHCCCS covers medically necessary services for cochlear implantation within certain limitations as described in this policy. Cochlear implantation requires prior authorization (PA) from the member's Contractor Medical Director, or from the AHCCCS Medical Director for fee-for-service members.

Cochlear implantation provides an awareness and identification of sounds and facilitates communications for persons who have profound, sensorineural hearing loss (nerve deafness). A cochlear implant is an electronic device, surgically inserted, which converts speech and other sounds into electrical signals and sends these signals to the auditory nerve. Evaluation, counseling and education prior to surgical implant are required to determine suitability of candidates for cochlear implantation. To ensure the successful outcome for an implant recipient, post-implant rehabilitation must be provided by professionals familiar with cochlear implants.

Cochlear implantation is a covered service for members 21 years of age or older when medically necessary.

Note: Refer to Chapter 400 for information regarding cochlear implantation coverage for members under 21 years of age receiving Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services.

Criteria for medical necessity include:

1. Diagnosis of bilateral profound sensorineural deafness, established by audiologic and medical evaluation

2. Prelingual/perilingual or postlingual deafness

3. Have an accessible cochlear lumen structurally suited to implantation, with no lesions in the auditory nerve and acoustic areas of the central nervous system, as demonstrated by CT scan or other appropriate radiologic evaluation

4. Absence of contraindications to surgery

5. Demonstrated cognitive ability to use auditory clues and a willingness to undergo an extended program of rehabilitation

6. Failure to show improvement with hearing aid trial (hearing aids are not a covered service for members who are 21 years of age and older)

7. No other medical treatment is therapeutic for the individual, and

8. Has no functioning implant in either ear.

Prelingually/perilingually deafened adult candidates, following evaluation by the primary care physician and expert specialists, must be reviewed on an individual basis by the Contractor Medical Director. The following information must be provided for this review:

1. The members current history and physical examination, including information regarding previous therapy for the hearing impairment

2. Records documenting the members diagnosis, current medical status and plan of treatment leading to the recommendation of implantation

3. Current psychosocial evaluation and assessment for determining the member's suitability for implant.

Amount, Duration and Scope. Coverage of cochlear implantation includes the following treatment and service components:

1. Complete auditory testing and evaluation by an otolaryngologist, speech-language pathologist or audiologist

2. Pre-surgery inpatient/outpatient evaluation by a board certified otolaryngologist

3. Diagnostic procedures and studies, including CT scan or other appropriate radiologic evaluation, for determining candidacy suitability

4. Pre-operative psychosocial assessment/evaluation by psychologist or counselor

5. Prosthetic device for implantation (must be non-experimental/non-investigational and be Food and Drug Administration approved and used according to labeling instructions)

6. Surgical implantation and related services

7. Post-surgical rehabilitation, education, counseling and training

8. Equipment maintenance, repair and replacement of external components, including replacement of the entire device if cost effective. Documentation which establishes the need to replace internal components not operating effectively must be provided at the time prior authorization is sought.

Cochlear implantation is limited to one (1) functioning implant per member. AHCCCS will not cover cochlear implantation in instances where individuals have one functioning cochlear implant. Binaural implantation is not covered.

Refer to Chapter 400 for information regarding cochlear implantation coverage for EPSDT members who are under 21 years of age.

Refer to Chapter 800 for treatment specifications, limitations and PA requirements for FFS providers.

- **HIV/AIDS TREATMENT SERVICES**

Description. AHCCCS-covered medically necessary treatment services, rendered by qualified providers, are available for the treatment of members who have been diagnosed with HIV/AIDS. Members who are diagnosed with HIV/AIDS are also listed as members with special health care needs. Chapter 500 describes the requirements for special health care needs members. AHCCCS requires Contractors to follow the Centers for Disease Control and Prevention (CDC) guidelines for the treatment of HIV/AIDS. It is the responsibility of each Contractor to distribute these guidelines, and all updates, to HIV/AIDS treatment professionals included in their network.

As appropriate, AHCCCS shall review new technological advances in HIV/AIDS treatment, including appropriate pharmacological regimens.

This review shall include the AHCCCS Chief Medical Officer, the AHCCCS Medical Director, Contractor Medical Directors and physician experts in the treatment of HIV/AIDS.

The review may include, but is not limited to, information regarding:

1. Established treatment and pharmaceutical regimens

2. Changes in technology and treatment protocols, and

3. Cost implications of treatment/pharmaceutical regimens.

Contractor Monitoring. Contractors must develop policies and protocols that document care coordination services provided to members with HIV/AIDS. This includes monitoring of member medical care in order to ensure that medical services, medication regimens and necessary support services (i.e., transportation) are provided within specified timelines, as defined in contractual arrangements with AHCCCSA, and that these services are utilized appropriately. Support services may be coordinated with existing community resources.

In addition, Contractors must ensure that the care for members diagnosed with HIV/AIDS, who are receiving services specified by and in accordance with the guidelines set by AHCCCS, is well coordinated and managed in collaboration with the member's treating physician.

If a conflict regarding treatment or denial of treatment arises between the member's treating physician and the Contractor Medical Director, the issue may be referred to the AHCCCS Medical Director, or designee. However, this does not preclude the member's right to file an appeal.

HIV/AIDS TREATMENT PROFESSIONALS

AHCCCS will compile, update and make available to Contractors, upon request, a listing of qualified HIV/AIDS treatment professionals (physicians, nurse practitioners and/or physician assistants). The listing will be based on information submitted by the Contractors.

A qualified HIV/AIDS treatment professional, for the purpose of this policy, is defined as a physician or practitioner who:

1. Is recognized in the community as having a special interest, knowledge and experience in the treatment of HIV/AIDS, and

2. Agrees to adhere to CDC treatment guidelines for HIV/AIDS, and

3. Agrees to provide primary care services and/or specialty care to AHCCCS members with HIV/AIDS, and

4. Demonstrates ongoing professional development by clinically managing at least five patients with HIV/AIDS during the last year, and meets one of the criteria below:

    a. Current Board Certification or Recertification in Infectious Diseases, or

    b. Annual completion of at least ten hours of HIV/AIDS-related Continuing Medical Education (CME), which meet the CME requirements under Arizona Administrative Code (A.A.C.) R4-16-101.

Limitations. A physician or practitioner not meeting the criteria to be a qualified HIV/AIDS treatment professional, who wishes to provide primary care services to a member with HIV/AIDS, must send documentation to the Contractor demonstrating that s/he has an established consultative relationship with a physician who meets the criteria for a qualified HIV/AIDS treatment professional as identified in this policy.

This documentation should be maintained in the Contractor's credentialing file. These practitioners may treat members with HIV/AIDS in the following circumstances:

- In geographic areas where the incidence of members with HIV/AIDS is low, and/or where there are no available AHCCCS-registered network HIV/AIDS treatment professionals meeting this criteria, or

- When a member with HIV/AIDS chooses a provider who does not meet the criteria.

Contractor Network. Contractors must include in their individual provider networks, sufficient numbers of qualified HIV/AIDS treatment professionals (physicians, nurse practitioners and/or physician assistants). Contractors must also have policies and procedures to assure that provider requirements and standards specified in the AMPM are met. Each Contractor provider network of HIV/AIDS treatment professionals is subject to review and approval by AHCCCS, Division of Health Care Management (DHCM). Contractors must submit, annually by December 15, a list of HIV/AIDS treatment providers to AHCCCS/DHCM/Clinical Quality Management Unit (CQM) which includes:

1. Name and location of all qualified HIV/AIDS treatment professionals treating members with HIV/AIDS, and

2. For each primary care provider (PCP) treating members with HIV/AIDS who is not a qualified HIV/AIDS treatment specialist, the name and location of the consulting HIV/AIDS treatment professional.

Contractors must also notify AHCCCS/DHCM/CQM of any material change to the HIV/AIDS provider network during the year.

Contractor policies must reflect that members with HIV/AIDS have freedom of choice to select an HIV/AIDS provider from the Contractor network. If the member elects to select a PCP in the Contractor network other than one of the providers designated by the Contractor as a qualified HIV/AIDS disease treatment professional, the member must be informed that only those designated providers are authorized to render treatment regimens such as antiretroviral therapies. The selected PCP must consult with a qualified HIV/AIDS provider and follow the recommendations of the consultant in order for the treatment regimen (such as protease inhibitors) to be a covered service.

- **LUNG VOLUME REDUCTION SURGERY (LVRS)**

Amount, Duration and Scope. Effective January 1, 2004, AHCCCS covers LVRS or reduction pneumoplasty for persons with severe emphysema when performed at a facility approved by Medicare to perform this surgery and in accordance with all of the established Medicare guidelines.

The member's treating physician is responsible for providing appropriate documentation, establishing medical necessity, and verification of compliance with Medicare and AHCCCS guidelines. The documentation must be sent to the Contractor Medical Director or, for AHCCCS fee-for-service members, to the AHCCCS Medical Director, when requesting authorization.

Where possible, such surgeries, and the required pre- and post-operative therapies, will be performed at facilities approved by Medicare for LVRS reimbursement within the State of Arizona. However, AHCCCS may cover this procedure at out-of-state facilities if needed. All facilities will be required to provide proof of Medicare LVRS facility accreditation as well as meeting AHCCCS Provider Registration requirements.

AHCCCS may pay for an adult caregiver to accompany members if medically necessary when out-of-state-travel is required. Transportation, lodging and board may be covered as appropriate.

MEDICARE CRITERIA

The Centers for Medicare and Medicaid Services (CMS) have adopted the following covered and non-covered criteria regarding lung volume reduction surgery:

Covered Indications for LVRS

Covered LVRS approaches are limited to bilateral excision of damaged lung with stapling performed via median sternotomy or video-assisted thoracoscopic surgery.

In addition, CMS has determined that LVRS is reasonable and necessary only if preceded and followed by a program of diagnostic and therapeutic services consistent with those provided in the National Emphysema Treatment Trial (NETT) and designed to maximize the patient's potential to successfully undergo and recover from surgery. The program must include a 6 to 10 week series of at least 16 and no more than 20 preoperative sessions each lasting a minimum of 2 hours. It must also include at least 6 and no more than 10 postoperative sessions, each lasting a minimum of 2 hours, within 8 to 9 weeks of the LVRS. This program must be consistent with the care plan developed by the treating physician following performance of a comprehensive evaluation of the patient's medical, psychosocial and nutritional needs, be consistent with the pre-operative and post-operative services provided in the NETT, and arranged, monitored and performed under the coordination of the facility where the surgery takes place.

CMS has determined that LVRS is reasonable and necessary only when performed at facilities that were identified by the National Heart, Lung and Blood Institute (NHLBI) as meeting the thresholds for participation in the NETT and at sites that have been approved by Medicare as lung transplant facilities.

Medicare will only consider LVRS reasonable and necessary when all of the following requirements are met and the patient satisfies all the criteria outlined as follows:

MEDICARE ELIGIBILITY CRITERIA * (AS OF AUGUST 20, 2003)

Assessment	Criteria
History and physical examination	Consistent with emphysema Body Mass Index (BMI) ≤ 31.1 kg/m^2 (men) or ≤ 32.3 kg/m^2 (women) Stable with ≤ 20 mg prednisone (or equivalent) daily
Radiographic	High Resolution Computer Tomography (HRCT) scan evidence of bilateral emphysema
Pulmonary function (pre-rehabilitation)	Forced expiratory volume in one second (FEV1) ≤ 45% predicted (≥ 15% predicted if age ≥ 70 years) Total Lung Capacity (TLC) ≥ 100% predicted post-bronchodilator Residual Volume (RV) ≥ 150% predicted post-bronchodilator
Arterial blood gas level (pre-rehabilitation)	PCO2, ≤ 60 mm Hg (PCO2, ≤ 55 mm Hg if one mile above sea level) PO2, ≥ 45 mm Hg on room air (PO2, ≥ 30 mm Hg if one mile above sea level)
Cardiac assessment	Approval for surgery by cardiologist if any of the following are present: unstable angina; left-ventricular ejection fraction (LVEF) cannot be estimated from the echocardiogram; LVEF < 45%; dobutamine-radionuclide cardiac scan indicates coronary artery disease or ventricular dysfunction; arrhythmia (> 5 premature ventricular contractions (PVCs) per minute; cardiac rhythm other than sinus; PVCs on EKG at rest)
Surgical assessment	Approval for surgery by pulmonary physician, thoracic surgeon, and anesthesiologist after pre-operative rehabilitation
Exercise	Post-rehabilitation 6-minute walk of ≥ 140 meters; able to complete 3 minute unloaded pedaling in exercise tolerance test (pre- and post-rehabilitation)
Consent	Signed consents for screening and rehabilitation.
Smoking	Plasma cotinine level ≤ 13.7 ng/mL (or arterial carboxyhemoglobin ≤ 2.5% if using nicotine products) Nonsmoking for four months prior to initial interview and throughout evaluation for surgery
Preoperative diagnostic and therapeutic program adherence	Must complete assessment and preoperative services program in preparation for surgery

* Patients must meet all criteria to be eligible for the procedure.

B. Non-Covered Indications for LVRS

1. LVRS is not covered in **any** of the following clinical circumstances:

   a. Patient characteristics carry a high risk for perioperative morbidity and/or mortality

   b. The disease is unsuitable for LVRS

   c. Medical conditions or other circumstances make it likely that the patient will be unable to complete the preoperative and postoperative pulmonary diagnostic and therapeutic program required for surgery

   d. The patient presents with $FEV_1 \leq 20\%$ of predicted value, and either homogeneous distribution of emphysema on CT scan**, or** carbon monoxide diffusing capacity $\leq 20\%$ of predicted value (high-risk group identified October 2001 by the NETT), or

   e. The patient satisfies the criteria outlined above, and has severe, non-upper lobe emphysema with high exercise capacity. High exercise capacity is defined as a maximal workload at the completion of the preoperative diagnostic and therapeutic program that is above 25 watts for women and 40 watts for men (under the measurement conditions for cycle ergometry specified above).

2. All other indications for LVRS not otherwise specified remain non-covered.

- **MEDICAL FOODS**

Description of Benefit. AHCCCS covers medical foods, within the limitations specified in this policy, for any member diagnosed with one of the following inherited metabolic conditions:

1. Phenylketonuria
2. Homocystinuria
3. Maple Syrup Urine Disease
4. Galactosemia (requires soy formula)
5. Beta Keto-Thiolase Deficiency
6. Citrullinemia
7. Glutaric Acidemia Type I
8. 3 Methylcrotonyl CoA Carboxylase Deficiency
9. Isovaleric Acidemia
10. Methylmalonic Acidemia
11. Propionic Acidemia
12. Arginosuccinic Acidemia
13. Tyrosinemia Type I
14. HMG CoA Lyase Deficiency
15. Cobalamin A, B, C Deficiencies

Definitions

1. Medical foods means metabolic formula or modified low protein foods that are produced or manufactured specifically for persons with a qualifying metabolic disorder and that are not generally used by persons in the absence of a qualifying metabolic disorder. Soy formula is also included within the limitations set by this policy when used by persons diagnosed with galactosemia.

2. Metabolic nutritionist means an AHCCCS registered provider who is a registered dietitian specializing in nutritional assessment and treatment of metabolic conditions.

Conditions, Limitations and Exclusions.

1. The diagnosis of the member's inherited metabolic condition must be documented in the member's medical record by the primary care provider (PCP), attending physician or appropriate specialist. Documentation should also include test results used in establishing the diagnosis.

2. Metabolic formula and modified low protein foods must be:

    a. Determined to be essential to sustain the member's growth within nationally recognized height/weight or BMI (body mass index) levels, maintain health and support metabolic balance

    b. Obtained only under physician order; and

    c. Supervised by the member's PCP, attending physician or appropriate specialist for the medical and nutritional management of a member who has:

        (1) Limited capacity to metabolize typical foods or certain nutrients contained in typical food; or

        (2) Other specific nutrient requirements as established by medical evaluation.

3. Metabolic formulas ordered for a member must be processed for the specific dietary management of the member's metabolic condition. The formula must meet the member's distinctive nutritional requirements that are established through medical evaluations by the member's PCP, attending physician or appropriate specialist, and/or the metabolic nutritionist.

4. Modified low protein foods must be formulated to contain less than one gram of protein per unit or serving. For purposes of this policy, modified low protein foods do not include foods that are naturally low in protein.

5. Soy formula is covered only for members receiving Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services and KidsCare members diagnosed with galactosemia and only until they are able to eat solid lactose-free foods.

6. Members receiving EPSDT services and KidsCare members receiving diagnosed with a metabolic disorder included in this policy are eligible for services through Children's Rehabilitation Services (CRS).

    a. Members receiving EPSDT services and KidsCare members must receive metabolic formula through CRS

    b. Members receiving EPSDT services and KidsCare members who require modified low protein foods receive them through AHCCCS Administration.

7. Medical foods must be ordered from a supplier of metabolic formula, modified low protein foods or soy formula that is approved by AHCCCS. Foods purchased through grocery or health food stores are not covered.

8. AHCCCS Administration is responsible for providing both necessary metabolic formula and modified low protein foods for members 21 years of age and older who have been diagnosed with one of the inherited metabolic disorders included in this policy.

9. Contractors remain responsible for initial and follow-up consultations by a genetics physician and/or a metabolic nutritionist, lab tests and other services related to the provision of medical foods for enrolled members diagnosed with a metabolic disorder included in this policy.

Approval Process

1. Upon completion of the member's initial consultation with a genetics physician and metabolic nutritionist, and the determination of metabolic formula and/or low protein foods necessary to meet the member's nutritional needs, the request is forwarded to the contact person for metabolic nutrition at AHCCCS/Office of Medical Policy and Programs (OMP) for review and processing.

2. After review and approval, the AHCCCS/OMP contact person forwards the order to the appropriate supplier to be filled.

3. The supplier then completes and ships the order to the member and sends the claim to AHCCCS Administration for payment.

4. All necessary management and ordering of medical foods are conducted through AHCCCS/OMP. Contractors will be informed of services provided through AHCCCS Administration for enrolled members who are diagnosed with one of the included metabolic conditions, however, all approvals and payments for medical foods are the responsibility of AHCCCS Administration.

5. Coordination of payment between AHCCCS Administration, CRS and/or private insurance carriers, as well as communication with the medical food suppliers, will be provided through AHCCCS/OMP.

See Appendix D of this Manual for flow charts addressing the process used in ordering metabolic foods.

- **TELEMEDICINE**

Description of Benefit. AHCCCS covers medically necessary consultative and/or treatment telemedicine services for all eligible members within the limitations described in this policy when provided by an appropriate AHCCCS registered provider.

Definitions.

1. Consulting provider means a licensed physician or clinical psychologist who provides an expert opinion to assist in the diagnosis or treatment of a member.

2. Medical professional personnel, for the purposes of this policy, include a licensed physician, registered nurse (RN), licensed practical nurse, clinical nurse specialist, RN midwife, registered nurse practitioner, physician assistant, behavioral health case manager, behavioral health professional or an occupational, physical, speech or respiratory therapist.

3. Real time means the interactive, two-way transfer of information and medical data, which occurs at two sites simultaneously: the hub site and the spoke site.

4. Referring provider means a licensed physician, physician assistant, RN practitioner, RN midwife, or clinical psychologist who arranges a telemedicine consultation to assist in the diagnosis or treatment of a member.

5. Telecommunications technology, which includes store and forward, means the transfer of medical data from one site to another through the use of a camera, or other similar device, that records (stores) an image which is then sent (forwarded) via telecommunication to another site for teleconsultation. Services delivered using telecommunications technology, but **not** requiring the member to be present during their implementation, are **not** considered "telemedicine". These services would be considered the same as services delivered on-site.

6. Telemedicine means the practice of health care delivery, diagnosis, consultation and treatment and the transfer of medical data through interactive audio, video or data communications that occur in the physical presence of the member.

    a. Hub site means the location of the telemedicine consulting provider, which is considered the place of service.

    b. Spoke site means the location where the member is receiving the telemedicine service.

Conditions, Limitations and Exclusions.

1. Both the referring and consulting providers must be registered with AHCCCS.

2. A consulting service delivered via telemedicine by other than an Arizona licensed provider must be provided to a specific member by a physician or clinical psychologist licensed to practice in the state or jurisdiction from which the consultation is provided.

3. At the time of service delivery via real time telemedicine, the member's health care provider may designate a trained telepresenter to present the case to the consulting provider if the member's primary care provider or attending physician, or other medical professional who is familiar with the member's medical condition, is not present. The telepresenter must be familiar with the member's medical condition in order to present the case accurately. Medical questions may be passed on to the referring provider when necessary.

4. Services provided via telemedicine are billed by the consulting provider.

5. Nonemergency transportation to and from the telemedicine spoke site to receive a medically necessary consultation or treatment service is covered.

AHCCCS Division of Fee for Service Management does not require prior authorization (PA) for medically necessary telemedicine services performed by fee-for-service (FFS) providers. Refer to Chapter 800 for complete information regarding PA requirements.

Refer to Policy 310 of this Chapter and Appendix G of this Manual for complete information regarding covered behavioral health services for Title XIX and Title XXI members.

Refer to the AHCCCS FFS Provider Manual for complete information regarding billing procedures. This manual is available on the AHCCCS Web site at www.azahcccs.gov.

- **HIGH FREQUENCY CHEST WALL OSCILLATION (HFCWO) THERAPY**

High Frequency Chest Wall Oscillation therapy (HFCWO) is a form of chest physiotherapy that promotes airway clearance for retained pulmonary secretions. This form of therapy has been shown to be equally as effective as other forms of such therapy, such as postural drainage and clapping (CPT), flutter valve or blow glove, etc., in helping an individual with clearing secretions from the lungs. A HFCWO vest will not replace a percussor, caregiver and/or self-administration of chest physiotherapy unless it is demonstrated that these forms of therapy are no longer effective.

HFCWO requires prior authorization. All cases will be reviewed on a case-by-case basis. Requests for prior authorization must be accompanied by specific documentation in the individual's personal medical record that supports the medical necessity for HFCWO. Criteria for medical necessity include, but are not limited to, all of the following:

1. Diagnosis of cystic fibrosis, and

2. Documentation of excessive sputum production combined with the member's inability to clear the sputum without assistance, and

3. Copy of chest x-ray report and pulmonary function tests showing findings consistent with moderate or severe chronic obstructive pulmonary disease (COPD), and

4. Prescription signed by a M.D. or D.O. with a specialty in pulmonary disease, indicating the need for at least daily (or more frequent) chest physiotherapy, and

5. Age 2 years or older or 20 inch chest size, whichever comes first, and

6. Specific documentation of failure of other, more cost effective, methods of chest physiotherapy, or airway clearance, including CPT and flutter valve, and

7. Specific documentation supporting why HFCWO therapy for the member is superior to other more cost-effective therapy methods, including at least one of the following:

   a. Promotes independent self-care for the individual, or

b. Allows independent living or university or college attendance for the individual, or

c. Provides health stabilization in single adults or emancipated individuals without able partners to assist with CPT, or

d. Severe end-stage lung disease requiring complex or frequent chest physiotherapy.

8. Evidence that the member can use the vest effectively, including continuing compliance with all forms of prescribed therapy and treatment and member and family acceptance of HFCWO therapy, and

9. Coordination between the provider office or clinic and AHCCCS or other payer source, such as ADHS/CRS or AHCCCS Contractor, prior to implementation of HFCWO therapy for long-term use.

Discontinuation Criteria For HFCWO

Discontinuation criteria for the HFCWO vest include, but are not limited to, the following:

1. Patient and /or prescribing physician request

2. Patient treatment compliance at a rate of less than 50% usage as prescribed in the medical treatment plan, to be checked at two (2) and six (6) months of usage.

HFCWO For Members Without Diagnosis Of Cystic Fibrosis

HFCWO is a covered service for adult members (age 21 and older) who meet all of the above criteria for medical necessity (except for diagnosis of Cystic Fibrosis), but who have a diagnosis such as chronic bronchiectasis or alpha-1 antitrypsin deficiency where there is an acute exacerbation of the illness or the disease is in the terminal stages. AHCCCS Contractor Medical Directors, or the AHCCCS Medical Director for FFS members, shall perform a case-by-case review to determine that HFCWO therapy is superior to other, more cost effective, forms of therapy. Prior authorization is required.